

Different Constellation and Shining Stars: Lesbian parents' experiences of accessing healthcare for their adopted children in England

Submitted by Lucille Kelsall-Knight RN (Child), BNurs (Hons), MSc

Student Number: 1120769

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Abstract

Introduction:

The past few decades have seen significant changes in family demographics. It is now more common for parents to be lesbians, which is due to increased social acceptance and the dissolution of legal barriers to parental responsibility. Adoption transforms the lives of some of the most vulnerable children. In 2019, 1 in 7 children in England were adopted by same-sex parents. Adopted children have an increased incidence of additional health care needs and therefore dental and medical appointments in comparison to children who remain with their biological parents.

Aim:

This study sought to explore the experiences of lesbian mothers accessing healthcare for their adopted children in England and the rhetoric, language and treatment they encountered.

Method:

A small scale qualitative study, utilising a Narrative Inquiry approach was the chosen method. The study population gained by purposive sampling was of six lesbian adoptive parents. A combined data analysis tool was utilised which used critical incident recall (Webster and Mertova, 2007) and broadening, burrowing, storying and re-storying (Clandinin and Connelly, 1990). A composite character couple was created to 're-story' the participants' experiences in healthcare and to maintain anonymity.

Results and discussion:

The needs and challenges of lesbian adoptive families may be different to those of heterosexual and biological families when accessing healthcare. There was an undercurrent of discriminatory practice, shown by various healthcare professionals, and a lack of understanding of the adoption process, knowledge surrounding the child's history and legal stance with regards to parental responsibility. Emergent themes were: navigating heteronormativity, navigating healthcare settings and professionals and having an 'adopted' status, intersectional identity of lesbian parented adoptive families accessing healthcare, reflective imagery of lesbian parents and adoptive families and professional expectations. Self-imposed strategies instigated by the parents to strengthen and protect their familial identities were also discovered.

Implications and recommendations for practice:

The findings demonstrated that the healthcare provider must take more proactive steps to ensure that practitioners are adhering to Equality legislation and professional standards and are not discriminating against same-sex parents and adopted children who utilise healthcare services. Practitioners should also receive training to ensure they are aware of the adoption process in England; diversity of the population in which they practice; the importance of appropriate terminology and families seeing positive representation of adoption and same-sex parenting in healthcare settings.

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Prologue

This thesis presents a story throughout and allows me, the researcher, to fully immerse myself into Narrative Inquiry and to then re-story the findings into an emerging narrative regarding lesbian parents accessing healthcare for their adopted children. Narrative is a powerful tool; whilst storytelling enables children to make sense of the world, is also allows adults to make sense of situations; albeit on a higher level of understanding. Each chapter is presented in a free flowing narrative with the aim of the thesis being a story of a multitude of people's experiences being heard and then presented for everyone who wishes to read this thesis to hear.

In order for you, the reader, to understand my perspective from the outset, I have included a personal narrative regarding my journey as a doctoral student, gay woman and adoptive parent. The narrative, I believe, is fundamental for you, the reader, to understand where I have come from and the experiences that I have encountered, which have led me to this thesis. There have been significant changes in recent history with regards to the rights of Lesbian, Gay, Bisexual and Transgender (LGBT) people in England, including same-sex marriage and adoption. These self-titled 'gay' rights are much more than that, they are human rights. A human right to love one another, regardless of sex or gender. A human right to become a family. A human right to have inclusive access to healthcare.

This thesis aims, through the power of narrative, to give a voice to the lesbian parents who accessed healthcare for their adopted children in England.

Chapter 1 – Introduction

1.1 My story

Different people will define a journey in varying ways; it may be a distance traversed, the movement from one position to another or it could signify a selfless act to achieve a goal (Moeller and Whitehead, 2015). On a personal level I believe that it is the multiple chapters encountered within life which have built up the physical and emotional tiers to form the structure of self. In essence it is the scaffolding which provides strength and ultimately allows the development and assembly of the individual. The journey that has been negotiated by me thus far has caused intrinsic quarrelling and extrinsic conformity, however my reality of the world, and all future journeys, are based upon the ideology of the linguistic turn, as the significance and worth of objects and experiences surrounding me can be ascertained through their depiction and interpretation (Saussure, 1916; Foucault, 1978; Butler, 1990). Knowledge of the linguistic turn has allowed me to have an understanding that language can constitute reality (Saussure, 1916; Foucault, 1978; Butler, 1990). When discussing a journey, be it through life, or metaphysical, there is a place for reflexivity. Reflexivity will be entwined throughout this thesis as it allows the interpretation of information by recognising the significance of what I, as the researcher and due to my personal characteristics, understand of the events that have occurred (D'Cruz, Gillingham and Melendez, 2007).

The person that I am is due to the varying situations that I have experienced (and will continue to experience) throughout my life, therefore my future self will also be shaped by these experiences. These situations have allowed me to explore, emerge and ultimately progress. To realise progression throughout

this thesis it is vital to recognise influences within early life experiences as these have shaped a basis on which to understand individual philosophical positioning. At the age of ten and living in a Worcestershire village, sporting a South-Welsh accent and the occasional Smurf blue tinge to my skin due to having Congenital Heart Disease, I left the local primary school and entered into an all-girls independent school in the city. It was here, over the coming nine years, that philosophy would be discussed, Latin learnt and another family realised. A family of friends with many differences; accents, divorced parents, adopted children. These varying traits enabled me to understand different family constellations from a young age. As a family the world outside the walls of the school was terrifying, but inside those walls was safe. Outside of the walls we were different to everyone else, but inside we became our own society, our own family. The virtues which had singled us out as 'different' and 'not the norm' in the wider society were the virtues that made us who we were and we embraced them (Douglas, 2002). As time has passed I recognise that a movement of utopian socialism was occurring and as pupils there was no need for any class battle or political insurgency to arise for socialism to emerge (Taylor, 2013; Engels, 2014). The school family were like-minded people and part of a wider society who were viable as a unit of solidarity both inside and outside the school walls. Looking at the school now and attending alumnae events there is a recognition that my influence within the school has remained, even though I have long since completed compulsory education. Similar to the work of Derrida (1987) the empty space that exists within an environment because the person or object has left does not mean that their presence and their viewpoints are not heard within the space.

School was enjoyable; it fuelled a desire to learn. With extra-curricular activities a plenty and an extrovert personality, a natural step was to engage in drama classes. Symbols and dramatization enabled me to suppress the person that I was and to provide some obscurity from the culture and lifestyle that I was becoming accustomed to (Turner, 1982; Schwarz, 2003; Luckhurst, 2008). By utilising the theatre curtain as a veil there was also a concealment of myself from the world outside of the utopian society. Hiding away from the wider society continued for a great deal of time until the recognition that my growth, as a multifaceted person, was being stunted as I was not brave enough to fully immerse myself into the culture and subculture that existed outside the school walls; it was in unity with school peers that acceptance and therefore emancipation was achieved. The establishment which provided my compulsory education was similar to the Sophists in that it charged termly fees in exchange for knowledge (Waterfield, 2009; Plato, 2012); it also had a liberal viewpoint derived from a Christian ethos, a notion of acceptance, tolerance and compassion. This viewpoint has stayed with me as I acknowledge that philosophical thinking begins by considering the person and their feelings. Comparable to Descartes I have feelings and I think, therefore I know that I exist (Waterfield, 2009), however the culture which I inhabit is changing constantly and therefore my feelings and perceptions will also alter as a result. I realise that the current political and social climate of the world is different to twenty years ago and it will alter again as people change the culture around themselves due to behaviour and interactions (Nietzsche, 1881, in Olkowski, 2012; Sartre, 2007). As both my compulsory and higher education continued, the interest in philosophy deepened; however the monopolisation of women

who taught in the all-girls school led to a fascination and continued alignment with feminism up to and including this thesis journey.

I self-identify as a cis-gendered¹ gay woman. Although the label of being a lesbian is often attributed to women in same-sex relationships, due to my own experience of the term lesbian being used in a derogatory manner, I prefer the label of gay women, although I will identify as a lesbian, if necessary, for demographic labelling purposes. Due to progressive LGBT rights within the United Kingdom (UK), I am married and my wife and I have two adopted children. Professionally I am a children's nurse and my current role is a lecturer in children's nursing. The majority of my professional role is spent teaching nursing students. A proportion of my parental role is spent ferrying the children to hospital appointments and ensuring that their health needs are met on a daily basis. Therefore personal interest and experience led to a desire to research lesbian parents' experiences of accessing healthcare for their adopted children for my thesis. The main reason being that personally encountering different health care professionals has offered dissimilar consultations which may have an emotional impact on the whole family unit. These encounters, which I have viewed through the lens of a gay parent with adopted children as well as a registered nurse, have led to an increased awareness of the attitudinal and institutional barriers to the implementation of the codes of professional practice and the professional duties that must be met; these codes assert that professionals must treat people as individuals and maintain their dignity by recognising diversity, increasing inclusivity and by avoidance of making

¹ A cis-gendered person is a person whose sense of personal identity corresponds to the sex and gender assigned to him or her at birth (Oxford English Dictionary, 2015)

assumptions about the individual or family (General Medical Council, 2014; Nursing and Midwifery Council, 2015), which anecdotally has not always been witnessed. Adopted children are known to have identity struggles and uncertainty throughout their lives (Tasker and Bellamy, 2007; Golombok, 2015) as adoption can make children appear to be different to their peers (Mellish, Jennings, Tasker, Lamb and Golombok, 2013). A child being adopted **and** having same-sex parents may create another element to the perception of being different (Verrier, 2009; Golombok, 2015). Therefore the thesis element of my doctoral journey is an opportunity to represent, challenge and potentially alter the idealised version of the nuclear family based on the normative of heterosexuality and whereby only biological children are recognised. It will do this by presenting how lesbian parents are treated in the government funded National Health Service (NHS) by acknowledging terminology used by healthcare professionals and exploring the extent to which differing family dynamics or constellations are recognised (Dibley, 2009; Chapman, Wardrop, Freeman, Zappia, Watkins and Shields, 2012a). Whilst each person views the world and its reality differently (Foucault, 1978), it is imperative that health care professionals acknowledge the family constellation with same-sex parents with certainty and inclusivity. The need to investigate this topic was also confirmed by the literature review as it was evident that despite the UK being one of the most inclusive countries in the world for LGBT legal rights, there is no British research available examining lesbian parents' experiences in accessing healthcare for their children (Hill, 2012). It is a necessity that children feel safe and protected and that they can grow up in an environment where they are understood and feel secure (Piaget, 1972); this is especially true when the child is adopted and they may have already encountered a lack of safety and/or

security with their biological family. Therefore it is vital that when same-sex parent's access health services with their children that they are acknowledged as a family and that no uncertainty is displayed through the use of inappropriate terminology. Positivity and certainty by the healthcare professional whilst acknowledging the family will improve the inclusion of the parents and their children and will provide assurance of the viability of the family unit (Verrier, 2009). The key elements of this thesis focus on the treatment of lesbian parents, the treatment of adopted children and the intersection of these elements.

When I began the doctoral journey, I read widely around autoethnography and considered it a preferred methodological approach as it allowed me to provide a reflexive self-narrative which explored personal experience and interconnected it with wider social, cultural and political meanings (Chang, 2009). However, over time and supervisory meetings I altered my stance (as discussed in 3.4) and developed an interest in Narrative Inquiry which would enable me to 'hear' the voices of others. Further discussions continued and my supervisors, peers and family gave me confidence to also entwine my own story within the thesis through using the Narrative Inquiry approach, due to the importance, power and value of self-experience (Ellis and Bochner, 2000). Atkinson and Delamont (2006) and Clandinin and Connelly (2000) discuss that telling and sharing stories and narratives have a profound ethical strength and an important social function as storytelling is a method to teach cultural norms and differences, which includes ethics and values. Therefore by engaging in Narrative Inquiry between myself and the participants, experiences and the terminological meaning of words such as family, LGBT, parents and adoption could be

explored and their meaning and perception unearthed for the participants.

Narrative researchers inquire about and aim to represent and understand the experiences of themselves and others. They also seek meaning of these events through utilising storytelling (Clandinin and Murphy, 2009); participants to the research may develop through their storytelling, an understanding of their experiences and then provide examples of the terminology heard in healthcare which would highlight inclusive and/or exclusive practices within healthcare.

For me, it has been important to hold an awareness of the word family throughout the thesis, and its definition has been pivotal, as has the acknowledgement of same-sex parents in healthcare. Definitions of family include: a group with two parents and their children living together as a unit, the offspring of a common ancestor, a group of people who are related to each other, such as a mother, a father, and their children (Gil de Lamadrid, 2013). As societal norms and laws (Adoption and Children Act, 2002) diversify, then so will the definition of a family, therefore its very existence can be fluid and thus non-binary (Bauman, 1991).

Earlier in this section I wrote about the importance and impact that school had on me; my teachers saw my flair for being a performer and so encouraged me to develop my skills and persona through drama. Therefore drama was a huge part of my school life and provided protection for me when I was an adolescent, therefore I have entitled this thesis: *'Different constellation and shining stars: lesbian parents' voices on accessing healthcare for their adopted children in England'*. The reason for this title is the word 'different' signifies a move away from the normative and the word 'constellation' represents family, with the

shining stars being the voices of the participants (parents) sharing their experiences. In order to promote the anonymity of the participants and protect their individual identities whilst also acknowledging my love of the dramatic arts, I decided to develop a composite character couple to merge the participants' stories and re-story them, as this enabled a reduction in the risk of the participant's identities and those of their families being exposed. Gutkind and Fletcher (2008) explain that in performances that are adapted from real or fictional narratives, a composite character is often created, which is a character based on more than one individual from a story. This method is commonly used when adapting a fictional novel into a screenplay for television or a film. Once the composite characters were developed I wanted to utilise their story further, therefore I wrote a children's book (Kelsall-Knight, in press), which has been accepted for publication. I believe that it is important for all people to see their own reflection in mainstream media. When children with same-sex parents attend healthcare settings, there are no children's books that can be used as a tool to ease their fears by reflecting same-sex parents (including dual heritage) and adopted children within a hospital setting. The book was written to address that gap and to create a status quo so that children can see their family constellation and identity reflected outside of the family itself.

Throughout my thesis (and life journey) I have immersed myself with culture and subculture which has allowed perception and multi-versal truths to be constructed. One of the many truths that I hold is that that as a parent my children are too young to comprehend concepts of societal construction such as sexuality. However they understand the construct of our family. A family through the lens of their ages and life experiences, regardless of its

constellation, is constructed through love. A family needs to feel included and accepted, irrespective of the environment within which it is encountered. I crave that through elements of my thesis I can protect their future and ensure that inclusivity in healthcare becomes a lived reality.

1.2 Thesis structure

This thesis has a narrative structure, however it has some 'traditional' thesis structure replication in order to allow the reader to 'follow a path' through the work. This chapter has provided a personal narrative whereby the thesis was introduced alongside my personal background.

In chapter two, the literature review chapter, I detail some of the underpinning literature that provided contextualisation for this project. I will present literature surrounding the legal stance of lesbians in England and detail the adoption process. Following this the literature search process will be explained, which leads onto a critical appraisal of current literature surrounding LGBT parents accessing healthcare for their children. The current gap in knowledge that I aim to contribute to will also be determined.

In chapter three, the methodology chapter, I explore my philosophical positioning initially, before moving on to consider the theoretical frameworks of feminist and queer theory, which underpin this study. I then discuss the methodology of Narrative Inquiry, including its background and my own route to deciding on utilising this method. This leads on to a justification of data collection tools, data analysis and ethical considerations of the study.

In chapter four, the findings and discussion chapter, I present the findings of the study. This is done through re-storying the participant's stories, and the composite characters giving life to the stories. Analysis of their stories with theoretical linkage is weaved throughout.

In chapter five, the conclusion chapter, I discuss the original contribution to knowledge and an overview of what has been achieved by this study. I then move on to make recommendations for practice and suggestions for further research. The conclusion chapter precedes my final personal narrative, the epilogue, which brings the thesis to a close.

Chapter 2 – Literature review

2.1 Introduction

In this chapter I will begin by reviewing the legal and theoretical literature pertaining to the history of lesbian rights within England and the adoption of children in England, including the statutory requirements of a child in care accessing healthcare. I will also consider the legal framework of the Equality Act (2010) due to healthcare being provided by a government organisation and also the professional expectations of healthcare professionals as guided by their professional, regulatory and statutory bodies. Following this I will provide an overview of the literature search method employed in the search for theoretical arguments pertaining to the experiences of LGBT parents accessing healthcare for their children. An overview and critique of the theoretical arguments in the area and the wider societal context in which these experiences are situated is subsequently presented, which identifies the gap in this literature that my research aims to respond to and my resulting research questions.

Prejudice is seen to be an unfair opinion, formed without enough knowledge (Cambridge English Dictionary, 2020) which can create discrimination; treating a person or particular group of people in a worse way from the way in which others are treated, normally on the grounds of, but not limited to, their skin colour, sex or sexuality (Cambridge English Dictionary, 2020). Born out of prejudice and discrimination is oppression, which is a situation in which people are governed in an unfair manner and prevented from having opportunities and freedom (Cambridge English Dictionary, 2020). This thesis highlights the prejudice, discrimination and therefore oppression that is experienced by

lesbian parents when accessing healthcare for their adopted children in England.

For the purpose of this thesis **English** law and context will be applied throughout as all of the participants in the study resided in England and had accessed healthcare services from the NHS in England.

2.2 A history of lesbian rights in England

In order to immerse fully within this thesis, it is important to have an awareness of the historical context of lesbian rights within England, which have evolved significantly over time.

The UK (which England is a country within), at its formation, was a Christian Kingdom. The influence of Christian doctrine underpinned the state and legislation, as such religion and homosexuality were in conflict. This led to same-sex sexual activity being deemed as 'sinful' and led to The Buggery Act (1533) that outlawed sexual activity between men and punishable by death (25 Hen. 8 c. 6). The Offences Against the Person Act (1861) removed the death penalty for homosexual acts, but imprisonment remained (9 Geo. 4 c. 31). This law remained in place until male to male sexual activity was decriminalised in 1967 in England. Sexual activity between women has never been criminalised within England (Norton, 2019), or subjected explicitly in any legislation. It was discussed within Parliament in 1921, however both the House of Lords and the House of Commons rejected any amendment to current legislation, which declared that homosexuality was a crime, to include lesbianism. This was because both sides were fearful that it would encourage women to explore

homosexuality and they also assumed that only a small percentage of the female population would be affected by such alteration to legislation (Stonewall, 2008).

In 1988, local authorities in England were informed of an amendment to the Local Government Act (1988), with the inclusion of Section 28. This resulted in legal positioning being altered once again, following on from the decriminalisation of homosexuality in 1967. Section 28 was a form of national state oppression against LGBT people as it prohibited the local authority from 'intentionally promoting homosexuality or publishing material with the intention of promoting homosexuality' or 'promoting the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship' (Local Government Act, 1988). Therefore all local education authorities were expected to provide educational curriculum policies which were adhering with the governments recommended approach that only heterosexual intercourse and relationships could be taught within schools. The amendment of this law led to LGBT groups self-censoring, and school support groups for LGBT children and young people being disbanded due to the fear that they would be seen as being in breach of the Act. This legislation remained in place until 2003, therefore during this time pupils who may have needed support or advice were unable to access it within their educational establishment, or to engage in any discussion surrounding LGBT issues.

Following the repeal of Section 28 in 2003, the Civil Partnership Act (2004) became legislation. This allowed same-sex couples to legally enter into binding partnerships, similar to marriage. The subsequent Marriage (Same-Sex

Couples) Act (2013) allowed same-sex couples in England to marry. This rapid alteration of the discriminatory law being overturned and legal rights relating to family life being extended to the gay community, tied in with further progressive law change with regards to same-sex parenting. Whilst legal protection such as the Equality Act (2010) and other legislation, as detailed above, has helped to address the injustice created by Section 28 and all other forms of discrimination gay people have been subjected to by the state; direct and indirect discrimination continues to affect individual and institutional attitudes. The swiftness of legal changes has led to both oppressive and progressive opinions co-existing surrounding same-sex relationships and parenting, however this rapid legal change has also been in light of British societal attitudinal shifts. In 1983, 70 percent of the British public believed that sexual relations between two people of the same sex was wrong, however by 2012 35% of the British public held this belief (Park, Bryson, Clery, Curtice and Phillips, 2013). There is no data regarding British attitudes towards homosexuality available post 2012 which highlights that there is a perception that oppressive and discriminatory attitudes no longer exist due to legal frameworks being in place to protect LGBT people.

Prior to the implementation of the Adoption and Children Act (2002) in 2005, children in England could not be adopted by people who officially identified as being gay or lesbian as they were explicitly excluded under the Children Act (1989). Solely removing the criteria for being married would not have automatically allowed same-sex couples to adopt. The Adoption and Children Act (2002) stated that an application to adopt a child in England and Wales could be made by either a single person or a couple and there was no necessity

to be married or heterosexual. This became legislation on December 30th 2005. Subsequently, in 2016 1 in 10 adoptions in England were to same-sex couples, by 2019 this had increased to 1 in 7 (DfE, 2019).

The demography of a family has changed significantly in recent history as it is now more common for parents to be lesbians due to an increase in social acceptance and the dissolution of legal barriers with regards to parental responsibility and medical advances (Ahmann, 1999; Shields, Zappia, Blackwood, Watkins, Wardrop, and Chapman, 2012; Mellish *et al.*, 2013; Golombok, Mellish, Jennings, Casey, Tasker, Lamb, 2014). It should be recognised that prior to the passing of the Adoption and Children Act (2002) lesbians were recognised as parents under English law, but they had most commonly become parents as a result of a previous heterosexual union, artificial insemination or surrogacy (Rose, 1994; Ahmann, 1999; Burkholder and Burbank, 2012; Golombok *et al.*, 2014). There is now an increased number of children with LGBT parents within the UK (Hill, 2012; BAAF, 2014; Golombok *et al.*, 2014) due to the inclusion of adoption of children being legal for same-sex couples; however the true number of LGBT headed family units are unknown (Hill, 2012).

2.3 Adoption of children within the United Kingdom

Children of all ages, cultures, religions and ethnic backgrounds may need a family through adoption (CoramBAAF, 2020). It is rare for an infant or child to be placed for adoption at the request of their biological parents; the most common reasons for children needing to be adopted are that they have suffered from abuse (physical, sexual, emotional or neglect) whilst living with their

biological family (AdoptionUK, 2020; CoramBAAF, 2020). Other reasons are that their biological parents may lack the knowledge and skills required to be a safe and effective parent, have addiction problems, been subjected to sexual assault resulting in pregnancy, or they may have poor physical and/or mental health (Hill, 2012; AdoptionUK, 2020). Children who have experienced neglect and abuse may find relationship building and trust difficult to establish with others (Verrier, 2009), they may also have long term health needs as a result of their early life and in-utero experiences (Verrier, 2009; Mellish *et al.*, 2013).

2.3.1 The process of adoption

There is a distinct difference in terms of legal responsibilities between adoption and being in foster care. Adoption Focus (2021) comment that a child in foster care is cared for by foster carers on behalf of the Local Authority and the biological parents. The foster carer has no legal rights or responsibilities in respect of the child and it is usually a temporary arrangement, although some fostering placements can be long-term. Whereas adoption is the legal process by which a child or a family group of children who cannot be brought up within their birth family become full, permanent and legal members of their new family, which continues throughout their lifetime (AdoptionUK, 2020; Adoption Focus, 2021).

There are many reasons why people choose to adopt, some may have experienced fertility problems or may have discovered that they are at risk of passing on a hereditary condition and therefore choose not to have a child that is biologically related to themselves. Alternatively a potential biological mother may have her own health complications which could be significantly exacerbated if she were to become pregnant. Other people may choose

adoption rather than sperm donation or surrogacy due to not being in a relationship, or if they are in a same-sex relationship or are transgender. There is also a school of thought that some families, due to their religious, ethical and emotional stance, choose to adopt because they believe they will be saving a child who otherwise would not grow up with the benefits of a loving and supportive family (Hill, 2012; AdoptionUK, 2020).

The adoption of a child involves adoption social workers matching and preparing both the child and adoptive parents for the adoption. In addition an Adoption Panel (a group of professionals and lay people) which is constructed by the adoption agency based in the local authority (LA) make a recommendation for adoption, which at this point is a collaborative agreement that the child/ren should be placed for adoption. The final decision is made by the Agency Decision Maker and this is confirmed and legalised by the Family Law Court. The Family Court will issue a Placement Order which will allow the adoption agency to begin searching for suitable adoptive parents for the child; once identified the prospective adopters will meet with the Adoption Panel. The Adoption Panel is responsible for recommending the matching and placement of a particular child/ren with prospective adopters. Once the child has been matched with adoptive parents, they must live with them for a minimum of ten weeks before the adoptive parents can apply to the Family Court to legally adopt the child². At the point that the Adoption Order is made, all legal ties to the biological family (such as parental responsibility and inheritance rights) are severed and are granted to the adoptive parents. Adopters become the child's

² Within this ten week minimum timeframe, parental responsibility remains shared between the biological parent/s and the local authority responsible for the child.

legal parents with the same rights and responsibilities as if the child was born to them. It is at this point that the adopted child can have their name legally changed to that of their adoptive family (Lord and Lucking, 2016). The flowchart of the process of adoption is shown in Figure 1³.

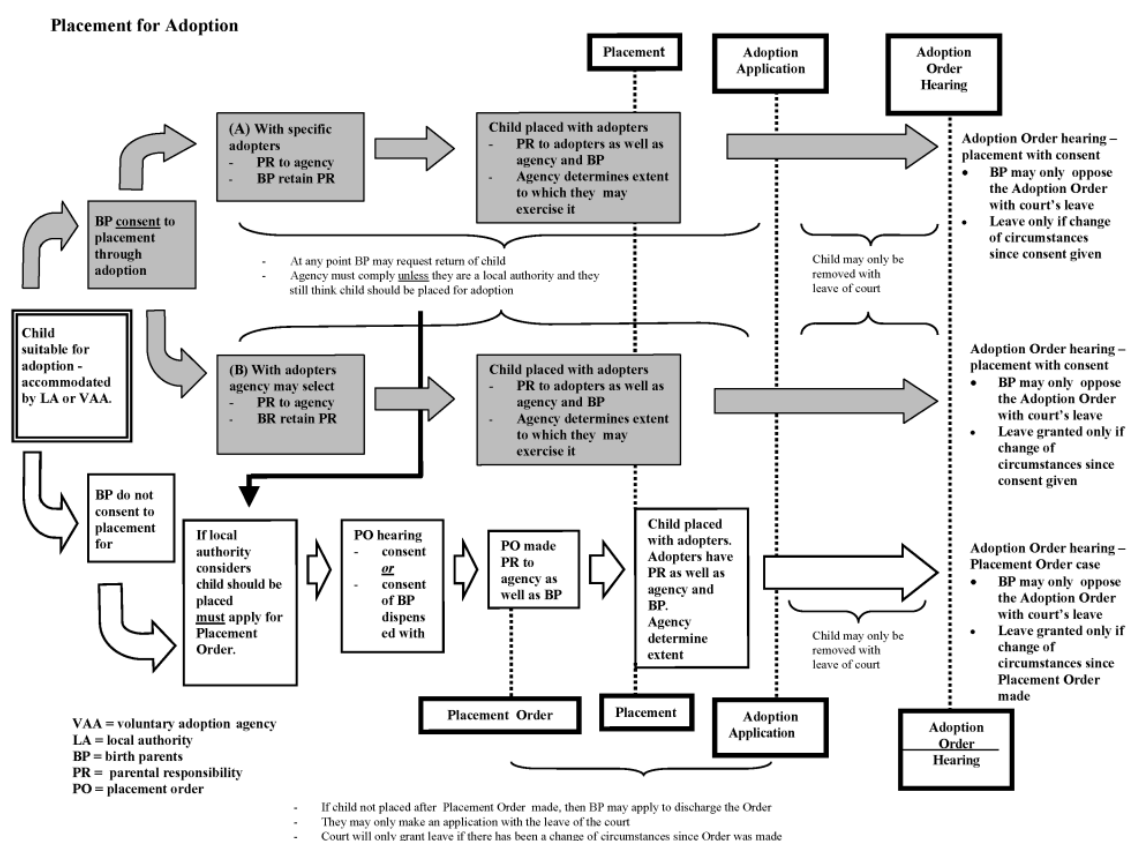


Figure 1: Process of placement for adoption taken from the Adoption and Children Act (2002): Annexe A

The statistics in relation to the adoption of children in England in 2018-2019 (DfE, 2019) are shown in Table 1. It details the number of children available for adoption and those that have been adopted in England. The data also

³ This image has been taken from Annexe A of the Adoption and Children Act (2002) and is subject to Crown copyright. Crown copyright material is made available to use free of charge under the Open Government Licence (OGL) and no other licence is required, therefore this information can be copied, published, distributed and transmitted.

highlights the demographic surrounding the sexuality and marital status of adopters.

Adoptions from Care	3,570 looked after children were adopted during the year ending 31 March 2019
Awaiting Adoption	4,020 children had an adoption decision but were not yet placed at 31 March 2018 2,630 children had a placement order for adoption but were not yet placed at 31 March 2018
Adopter Characteristics	During year ending 31 March 2019: <ul style="list-style-type: none"> • 88% (3,140) of children were adopted by couples and 12% (430) by single adopters. • 14% (490) of children were adopted by same sex couples (either in a civil partnership, married or neither).

Table 1: Statistics of children in care and adopted and the characteristics of adopters for 2018-2019

2.3.2 Looked After Child medical review

Prior to a child being adopted, they are classed as a Looked After Child and as such there is a statutory requirement that they have regular medical reviews (DoH, 2015b). A Looked After Child is a child who is in care (therefore the local authority has joint responsibility with the child's biological parent/s for them). If a Looked After Child ceases to be in care, for example they are adopted, return to their biological family or become subject to a Special Guardianship Order (SGO), they then become a Previously Looked After Child. Looked After Children and Previously Looked After Children have poorer life chances when compared with their peers, because of hereditary health issues and the long term effects of abuse (Bramlett, Radel and Blumberg, 2007; Mellish *et al*; 2013). Therefore statutory guidance exists to help decrease the health inequality gap. The Service for Looked After Children including Health Assessments is set out within the guidelines 'Promoting the health and well-being of looked-after children: Statutory guidance for local authorities, clinical commissioning groups

and NHS England' (DoH 2015b). The health of all Looked After Children is managed by the Community Paediatric Department. The aim of the health review is to identify the child's existing health problems and any deficits in previous healthcare and to provide a baseline for managing the child's future health needs. The review of the child's health plan must happen at least once every six months before a child's fifth birthday and at least once every 12 months thereafter (DoH 2015b). Whilst adoptive parents, at the point that they are being considered being matched with a specific child, will be given details of the medical history (and any relevant reports) regarding their child, they often have not attended the health reviews prior to the child being placed with them for adoption. The NHS duty to undertake the Looked After Child health assessment ends once the child moves to Previously Looked After Child status (when the Adoption Order is granted), despite their medical needs being ongoing. Their health needs then become the responsibility of the adoptive parents to manage, who may not necessarily be in receipt of the full medical history.

2.4 Promoting equality through professional standards

In the majority of cases, citizens in England have their health needs met by the NHS as it is the main healthcare provider. The NHS in England is served by many healthcare professions and professions allied to health. Therefore, there is an expectation of professionalism and a certain standard of care from those who access health services. Healthcare providers must be aware of the demography of the population in which they practice and deliver services which are inclusive to the diverse population that they serve (Shields, Zappia, Blackwood, Watkins, Wardrop and Chapman, 2012) through the use of appropriate terminology, whilst also being sensitive to their patients and

families, as children will attend healthcare settings with their parent/s.

Healthcare professionals are governed by professional and statutory regulatory bodies and have to adhere to codes of conduct. The General Medical Council (2014) stipulate in their conduct guidelines that doctors must not unfairly discriminate against patients or colleagues by allowing their personal views to affect professional relationships or the treatment they provide or arrange. They must also challenge colleagues if their behaviour does not adhere to that expected of a doctor and escalate their concerns if the colleague's behaviour amounts to abuse or denial of a patient's or colleague's legal rights. The Health and Care Professions Council (2014) which serve as the regulator for allied health professionals have similar expectations, its members should be aware of the impact of culture, equality and diversity on practice and should also practice in a non-discriminatory manner. Lastly, the Nursing and Midwifery Council (2018) expect and hold to account their members to ensure that they treat people as individuals and uphold their dignity and that they act with honesty and integrity at all times, treating people fairly and without discrimination.

It is a legal requirement under the public sector equality duty (Equality Act, 2010), that all state run health and social care organisations, and those in the independent sectors commissioned by the state to provide health and social care, actively consider the needs of LGBT communities and do not discriminate against anyone on account of the protected characteristic of sexuality.

Notwithstanding the law, policy and government recommendations (Stonewall, 2008; Equality Act, 2010; Commons Select Committee, 2019) homophobia remains present in many UK institutions, including the NHS, with patients and their families reporting prejudiced and discriminatory comments about sexual

orientation (Kelsall-Knight and Sudron, 2020). Incidents of discrimination should be reported through the complaints procedural process of the individual organisation and where necessary the employer organisation may have legal action taken against it (as opposed to the individual staff member). This is of important note as the law (Equality Act, 2010) recognises the responsibility of organisations to ensure an inclusive, non-discriminatory workforce and culture, rather than individuals. However, employees who are found to discriminate against others can also be held accountable by their regulatory body due to this being a breach of their professional standards. Reporting of discrimination requires someone to highlight the problem - either the person who is discriminated against or a witness to that discrimination (family member/staff); however some people may be reluctant to do this due to fear of retaliation or not being believed (Stonewall, 2008), therefore this may account for why discriminatory attitudes continue to persist.

Adopted children have an increased incidence of additional health care needs in comparison to children who remain with their biological parents (Verrier, 2009; Salter, 2013). There is an increased occurrence of adopted children accessing mental health services and attending dental and medical appointments than biological children (Bramlett, Radel and Blumberg, 2007); therefore LGBT adoptive parents' experiences of accessing healthcare services on behalf of their children is particularly important to ensure that it is inclusive and is being conducted in accordance with the Equality Act (2010) and that professional standards are being adhered to. If the same-sex parents are discriminated against this could have an indirect negative impact on the child's health and wellbeing and their access to inclusive health care. If this is coupled with the

disadvantages that adopted children have already overcome or are overcoming due to their early years experiences, this could further increase the negative effects and lead to a delay in positive health outcomes (Mellish *et al.*, 2013). Ultimately the welfare of the child is paramount (Children Act, 1989) and in accordance the child should be at the centre of all decisions made within the family. Family Centred Care is a government initiative which focuses on the collaborative planning, delivery, and evaluation of healthcare between healthcare professionals, patients, and their families (DoH, 2004). It is widely practised within the UK and is a standard and expected exemplar with which to provide care to all families (DoH, 2004). With this in mind it is important that the approach is implemented fully with the use of a sensitive healthcare professional who is aware and can educate others on the construction, contextualisation and the function of the LGBT family that is accessing the service.

2.5 Literature review focus in relation to LGBT parents in healthcare settings

Current viewpoints surrounding the health and wellbeing of adopted children have widened recently due to the acknowledgment of alterations within family construction (Bramlett, Radel and Blumberg, 2007). However the change in English law (see 2.2) has also led to controversial views regarding same-sex parenthood (Mellish *et al.*, 2013; Golombok *et al.*, 2014), such as perceptions that children raised by same-sex parents will be adversely affected by experiences such as bullying during childhood on account of their parents sexuality (Mellish *et al.*, 2013). When voiced, these oppressive views and comments could have an effect on the emotional health and wellbeing of children as the discriminatory attitudes towards same-sex parents may serve to further disadvantage already vulnerable children.

There is a plethora of research available which details the experiences of LGBT people in the healthcare arena (Allen, Glicklen, Beach and Naylor, 1998; Perlesz and McNair, 2004; Sharek, McCann, Sheerin, Glacken and Higgins, 2015), however there is a lack of research concerning LGBT parents' experiences of accessing healthcare services for their children (Shields *et al.*, 2012).

Suggested reasons for this paucity of research are a reluctance to disclose sexual orientation (Neville and Henrickson, 2008) due to previous negative experiences within healthcare as a result of discrimination (Perrin and Kulkin, 1996; Perrin, Cohen, Gold, Ryan, Savin-Williams and Schorzman, 2004; Dibley, 2009; Edwards and Van Roekel, 2009) and discomfort in a heterosexist healthcare environment (Chapman, Wardrop, Watkins, Zappia and Shields 2012d; Shields *et al.*, 2012). However, reluctance to acknowledge sexual orientation by the parents could cause confusion to children with regards to their family dynamic when they are accessing healthcare services (Perrin and Kulkin, 1996; Shields *et al.*, 2012).

2.6 Literature search process and outcomes

This section provides an overview of the literature search method employed in the search for theoretical arguments pertaining to the experiences of LGBT parents accessing healthcare for their children.

The specific objectives were;

- To identify the LGBT parents' experiences of accessing health services for their children.
- To examine the methodological quality of existing studies.

- To identify any gaps and/or shortcomings in the methodology of existing studies.
- To make recommendations for further research.

2.6.1 Key words

Key words are the words that encapsulate the crux of the research topic or question under review (Aveyard, 2014) and it is essential that they are suitable so that the literature search is effective, and appropriate data is produced (Crookes and Davies, 1998; Bernard, 2013). The key words used initially in the literature search mirrored the review question, with the terms 'LGBT parent' and 'accessing healthcare' being used separately and together, however these did not yield any useful results. The keywords and their definitions (Table 2) were expanded to include synonyms (Crookes and Davies, 1998). Boolean operators which are the terms "and", "or", make the literature search explicit as they combine the various key words (Bernard, 2013). These operators were employed in the search to aid in the combination of terms.

Term	Definition	Synonyms
Parent	Applies to all biological parents, regardless of their marital status or any person who has parental responsibility for a child or young person (Education Act 1996)	Mother Father
LGBT	Acronym for <i>Lesbian, Gay, Bisexual and Transgender</i> . The “LGB” refers to sexual orientation and if a person identifies as Lesbian, Gay or Bisexual. Sexual orientation is defined as a long lasting display of emotional, romantic and/or sexual attractions of men to women or women to men (heterosexual), of women to women or men to men (homosexual – Gay/Lesbian), or by men or women to both sexes (bisexual). The “T” stands for transgender or gender non-conforming, and is an umbrella term for people whose gender identity does not conform to that associated with the biological sex which they were assigned at birth (American Psychological Association, 2016).	Homosexual Lesbian Gay Bisexual Transgender
Experience	An event or occurrence which leaves an impression on someone (Oxford English Dictionary, 2016)	
Accessing/Seeking healthcare	The terms “ <i>accessing</i> ”, “ <i>seeking</i> ” and “ <i>healthcare</i> ” are used by many of the research papers to identify people who seek services for their health and wellbeing	
Children	The term ‘children’ feature highly in local and national guidelines and a child is commonly understood to be a person under the age of sixteen years (DOH, 2004)	

Table 2: Definition of terms used to inform the search

2.6.2 Inclusion and exclusion criteria

Crookes and Davies (1998) detail that inclusion and exclusion criteria focus the search and are a valuable addition which allows for a structured approach to enable a more strategic method. The inclusion criteria is shown and detailed in Table 3. Only the inclusion criteria is detailed as the exclusion criteria are self-explanatory as they are the opposite of the inclusive measure.

Inclusion criteria	Rationale
Key words	Key words were a necessary addition to the inclusion criteria to ensure that literature captured within the search addressed the review topic.
Primary research	Primary research is the most trustworthy and robust evidence (Aveyard 2014) therefore it was necessary for primary research to be included as a key inclusion criterion.
Date of publication	This initially was 2005 onwards due to the implementation of the Adoption and Children Act (2002) in the United Kingdom which allowed LGBT people to adopt children, however this timeframe yielded little data. Therefore the date of publication was extended to 1995.
Research whereby the parent was LGBT	It was important to focus the review onto the specific population as it allowed for distinct results to be retrieved.
Research where healthcare services were accessed for the children	There is a great deal of research available concerning access of healthcare services by adults, however there is a paucity regarding the access of services for children.
Worldwide	Initially only literature published in the UK and Northern Ireland was included however it yielded no results, therefore the inclusion criteria was extended to worldwide.
Peer reviewed	Peer review ensures that research findings are credible as they have been evaluated by experts (Bernard, 2013).

Table 3: Inclusion criteria used in the critical literature search

The PEO (Population, Exposure, Outcome) framework was used to explore the research aim as shown in Table 4, to complete a systematic review. This framework is used in health and nursing research to establish the fundamental elements of the research question, devise thorough and applicable search terms and formulate inclusion and exclusion criteria (Bettany-Saltikov and McSherry, 2016).

Population	Exposure	Outcome or themes
Lesbian adoptive parents	Healthcare settings	Experiences

Table 4: Population Exposure Outcome (PEO) framework

A rigorous search strategy is necessary to locate studies specific to the requirements of the literature review (Crookes and Davies, 1998. Aveyard, 2014) and to ascertain that the literature is credible and relevant (Polit and Beck, 2004). This thesis has a narrative focus, therefore in order to further promote a scientific robustness and credibility to the study it was important to maintain an element of a traditional framework which incorporated a robust and credible literature search (Grant and Booth, 2009). With this in mind, in order to conduct a rigorous search, relevant exclusive subject databases were employed (Table 5). The number of 'hits' gained in each of the databases due to the employment of keywords is also shown. The total number of database search hits was 172.

Database searched (1995-2020)	Rationale	LGBT parents experience of accessing healthcare for their children	LGBT parents experience of accessing healthcare for their adopted children
Cumulative Index to Nursing and Allied Health Literature (CINAHL)	A comprehensive database which includes references to many English and non-English journals, books, dissertations and conference presentations (Polit and Beck, 2004)	11	36
Medline plus full text	A source of bibliographic references, research with health related topics and evidence based literature (Polit and Beck, 2004)	13	32
SocINDEX	Comprehensive sociology database which encompasses the broad spectrum of sociological study (Bernard, 2013)	5	18
Nursing and Allied Health	Database with a diverse mix of scholarly literature, clinical training videos, reference materials, and evidence-based resources, including dissertations and systematic reviews (Gerrish and Lacey, 2010)	46	11

Table 5: Table of databases used in literature search

Once the databases had been searched some of the articles that had been found had studies within their reference list that were also considered for inclusion into the literature review. These results are shown in Table 6.

Type of article	Article reference
Literature reviews considered but not used for review but studies sought from the reference list	Shields <i>et al.</i> , (2012)
Other studies considered but not used for the review because they did not meet some of the inclusion criteria	Gartrell <i>et al.</i> , (1999); Chapman <i>et al.</i> , (2012b); Chapman <i>et al.</i> , (2012c); Chapman <i>et al.</i> , (2012d); Bennett <i>et al.</i> , (2016); Crouch, McNair and Waters (2017)

Table 6: Articles where the reference lists facilitated the recognition of further studies

2.6.3 Overview of studies that form the review

Initially the study abstract was examined to determine whether the research was appropriate for inclusion in the review (Crookes and Davies, 1998). The initial 'hits' of 172 (as shown in table 5) were reduced in number to 19 for final consideration for inclusion in this review. The reasons for those rejected from the 19 are detailed in Table 7 and include a literature review as it was not primary research, and primary research that did not meet the inclusion criteria.

Rationale for rejection	Total number of papers
Literature Review	1
Research not specifically related to the topic, did not meet the inclusion criteria	8

Table 7: Rationale for paper rejection from final literature review sample

The final number of studies included in the review was 10.

A qualitative approach was adopted by seven of the studies included in the final literature review; one was a descriptive, exploratory study (Chapman *et al.*, 2012a), one (Rawsthorne, 2009) insinuates phenomenology but is not explicit, two (McNair, Brown, Perlesz, Lindsay, De Vaus and Pitts, 2008; Appelgren-Engstrom, Borneskog and Almqvist, 2019) were grounded theory, two (Malmquist and Zetterqvist Nelson, 2013; Andersen, Moberg, Bengtsson Tops and Garmy, 2017) were inductive content analysis and one (Kerppola, Halme, Perala and Maija-Pietila, 2019) was a qualitative inductive study. All seven studies utilised semi-structured interviews, with two taking a grounded theory approach. One study (Goldberg, Frost, Manley, McCormick, Smith and Brodzinsky, 2019), with a sole focus on adoptive parents, was a mixed methods study which employed General Estimation Equations (GEE) and qualitative content analysis. Two studies (Perrin and Kulkin, 1996; Mikhailovich, Martin

and Lawton, 2001) were quantitative in nature but they also had qualitative inclusion by the employment of open-ended questions, with one adopting grounded theory (Mikhailovich, Martin and Lawton, 2001).

Researchers in general placed their focus on positive and negative experiences of LGBT parents within healthcare services and the satisfaction that they felt in the care and interaction that they had. The participants' sexual orientation varied throughout all of the studies. The LGBT population were represented, however there is only explicit inclusion of a bisexual participant in two studies. The family constellation was also varied with differing routes to conception of a baby, adoption and fostering all represented. An overview of the studies is shown in Appendix One.

Countries of origin; Australia (n=4) Sweden (n=3) Finland (n=1) United States of America (USA) (n=2)

2.6.4 Critical appraisal process and outcomes

Critical Appraisal Skills Programme (CASP) qualitative and quantitative tools were utilised to appraise the literature (CASP, 2013). Every study within this review identified an aim and justified the employment of a method which attends to the research question. The two quantitative studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001) need to be considered with care as they had very low response rates (8% and 23% respectively), however low response rates are consistent with blanket community mail-outs, which have been utilised in previous work within this area of study. Therefore it could be questioned whether quantitative research provides generalizable results within this minority group if the researchers are relying on community mail-outs alone. They may

have had a greater response if they had specifically targeted the LGBT population through attendance at an LGBT event such as 'Pride'.

All of the studies used purposive sampling, thus ensuring that the participants offered data fit to answer the research question (Aveyard, 2014). Snowball sampling also occurred in four of those studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Kerppola *et al.*, 2019) which allowed inclusion into the study of people who would be able to respond to the needs of the study (Polit and Beck, 2004; Crookes and Davies, 1998). Four of the studies featured lesbians only (McNair *et al.*, 2008; Rawsthorne, 2009; Malmquist and Zetterqvist Nelson, 2013; Appelgren-Engstrom, Borneskog and Almqvist, 2019) and McNair *et al.*, (2008), Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019) were the only studies to identify the ethnicity of the participants. Perrin and Kulkin (1996), McNair *et al.*, (2008), Andersen *et al.*, (2017), Appelgren-Engstrom, Borneskog and Almqvist (2019) and Goldberg *et al.*, (2019) were the only studies which reported on the social demographics of their participants and McNair *et al.*, (2008) chose to include a range of participant economic backgrounds in the interviews. This allows for a wider range of views to be sought which may have been different based upon the education level of the participants as it is acknowledged that people with higher education levels can be more assertive and therefore may find social and healthcare situations easier to navigate (Shields *et al.*, 2012). In the study by McNair *et al.*, (2008) all the children were biologically related to one of their LGBT parents therefore no adopters were included in the sample; conversely in the study by Golberg *et al.*, (2019) there was no biological relationship between any of the children and their adoptive parents (n=224), and 9.8% (n=22) adoptive parent participants were

people of colour. This highlights the spectrum of demographics as it is widely documented that children are predominately adopted by white, middle class couples (Bramlett, Radel and Blumberg, 2007; Mellish *et al.*, 2013).

Sample sizes for qualitative research are usually smaller than for quantitative research (Bernard, 2013) and indeed the sample sizes of the research used in this literature review fluctuate due to the inclusion of both quantitative and qualitative studies. However the sample sizes allow for a richness of data from the participants and thus the aim of the research for each study is met (Parahoo, 1997).

The research methods used were either questionnaire or interviews. The two quantitative studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001) utilised questionnaires. Perrin and Kulkin (1996) employed the strategy of an expert consultation panel prior to a questionnaire being devised to ensure that appropriate questions were constructed; this signifies its reliability and validity (Parahoo, 1997). Mikhailovich, Martin and Lawton (2001) do not disclose how they devised their questionnaire, therefore the validity of the tool could be questioned (Parahoo, 1997). In semi structured interviews the researcher is able to make a plan for topics that need to be discussed, then the participants provide the information based upon the agenda (Crookes and Davies, 1998). Malmquist and Zetterqvist Nelson (2013) employed a semi-structured interview. Four of the studies (McNair *et al.*, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019) included topic areas for the participants to focus on which allowed the reader to determine whether the research aim was met. Open-ended

questionnaires were used in two of the studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001) and whilst the open-ended exploratory nature of them allows for the participant to respond in any fashion, it relies on the participant providing coherent rich data within the free text box and not altering their response for their own agenda (Gerrish and Lacey, 2010). The study by Goldberg *et al.*, (2019) used Generalised Estimation Equations (GEE) to determine data based upon variables and an open ended question to explore the experiences that the (heterosexual, lesbian and gay) adoptive parents had with their children's paediatricians. The interviews in the qualitative studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Malmquist and Zetterqvist-Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019) were all conducted face to face, except for Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019). There is no discussion surrounding the locality of the research interviews in the study by Goldberg *et al.*, (2019). Kerppola *et al.*, (2019) allowed the participants to select either a face to face or telephone interview; whilst this is a useful situation as it enables the researcher to delve further for clarity if necessary (Parahoo, 1997), it also means that the studies (except for Kerppola *et al.*, 2019) were all representative of a specific locality due to travel distances. Therefore whilst qualitative research is not usually generalizable, in this instance it almost certainly is not due to the geographical perimeter that has been utilised. This would have been of particular note if the Perrin and Kulkin (1996) study had been qualitative in origin as the different states within the USA have varying laws with regards to parentage and LGBT persons. Three of the qualitative studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a) provided the participants with a transcript of the interview and asked for confirmation that the transcript was

representative of their views; this ensured the reliability and validity of the research (Corbin and Strauss, 2015). The studies completed by Malmquist and Zetterqvist Nelson (2013), Andersen *et al.*, (2017), Appelgren-Engstrom, Borneskog and Almqvist (2019), Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019) do not disclose if they provided the participants with a transcript.

A significant factor that needs to be taken into account is the relationship between the researcher and the participants (Polit and Beck, 2004). None of the studies explicitly stated the relationship and therefore ethical issues such as bias, coercion and power could not be acknowledged; however this definition of relationship may not have been declared due to wordage limits within publication (Crookes and Davies, 1998).

The studies used in this review are shown in the data extraction table in Appendix 1.

2.6.5 Synthesis of research findings

Following critical appraisal and analysis of all the studies which met the inclusion criteria, themes were identified by fingertip searching and highlighting areas of topic commonality in the research papers. The themes determined from the literature are:

- Attitudes and managing healthcare experiences
- Acknowledgment of sexual orientation
- Bureaucratic transformation

Prior to the thematic findings discussion in 2.7.1, 2.7.2 and 2.7.3, there will be an overarching discussion in 2.7 of the current literature findings.

2.7 Emergent themes of literature review

Ten studies met the inclusion criteria and explored the LGBT parents' experiences of accessing healthcare services for their children (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson (2013); Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019; Kerppola *et al.*, 2019; Goldberg *et al.*, 2019). LGBT parented families are increasing in the UK, however there are no British studies available which examine LGBT parents' experiences in accessing healthcare for their children; despite, as previously noted, the UK being one of the most forward thinking countries in the world with regards to LGBT rights and LGBT parental law (Adoption and Children Act, 2002; Stonewall, 2008; Hill, 2012). The USA, Australia, Finland and Sweden were the only countries represented in the review and they all have a different healthcare service to the UK (as the National Health Service, which is free to all at the point of entry, is unique to the UK) and the countries all have varying legislation regarding the recognition of same-sex parents. Therefore, the findings of the studies in this review are specific to their country of origin and legislation, and not generalizable.

The needs and challenges of LGBT families may be different to those of heterosexual families due to challenges with identity and routes to parenthood (Mellish *et al.*, 2013; Golombok *et al.*, 2014) and the reviewed studies all highlighted that participants had positive and negative interactions with healthcare professionals. In Perrin and Kulkin's (1996) American study of 255 participants, 40% of the participants were unhappy with their experience of accessing healthcare for their children. However a later study (Kerppola *et al.*,

2019), undertaken in Finland with a sample size of 22, has no statistics associated with it, and although highlights that LGBT parents are having some positive experiences with healthcare providers for their children, there are some negative experiences that remain. This is also echoed in the Goldberg *et al.*, (2019) American study, however the focus is on adoption competence⁴ rather than LGBT inclusion. The studies reveal that discrimination remains alongside fears of disclosure of sexual orientation and lack of knowledgeable staff with regards to the needs of LGBT people (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019; Kerppola *et al.*, 2019). However these concerns did not appear as frequently in the latter reviews which could be due to recent changes in social policy and increasing social acceptance (Chapman *et al.*, 2012a; Hill, 2012). It is apparent that health professionals still require further education on the specific concerns and issues which LGBT parents accessing healthcare for their children may encounter. This could further be an issue in relation to the adopted child, whereby they may be feeling uncertain about their identity and they would need to be managed sensitively yet with certainty (Verrier, 2009; Mellish *et al.*, 2013; Goldberg *et al.*, 2019).

The completion of documentation (most notably registration and hospital admission forms) that was normative heterosexist in nature was highlighted by nine studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton 2001;

⁴ Adoption competence encompasses 'knowledge about adoption practices and the impacts of adverse early experiences, skills to address the needs of individuals involved in adoption, cultural competency and preparation to honour and support diversity' (Goldberg *et al.*, 2019. p4)

McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019; Kerppola *et al.*, 2019) and often led to the parents self-disclosing their relationship. The healthcare provider should be aware of the diversity of the population in which they practice and should deliver inclusive services (Shields *et al.*, 2012; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) through the use of appropriate terminology and also offer sensitivity to their patients and families as children will attend healthcare settings with their parent/s. This should also include an understanding of adoption and the background of the child (Goldberg *et al.*, 2019). The documentation utilised in the health settings must be fit for practice; it must serve the whole community, and make sure that no person is excluded or discriminated against (DoH, 2015a) and that it is inclusive to the diverse population (Kerppola *et al.*, 2019).

The studies all found that disclosure of sexual orientation to healthcare professionals was overall beneficial, however it should be recognised that even though a healthcare professional must act in a non-judgmental manner (GMC, 2014; HCPC, 2014; NMC, 2015), if they have innate homophobic attitudes then the LGBT parent may not receive as positive a reaction to the disclosure. Four of the studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; Rawsthorne, 2009; Goldberg *et al.*, 2019) included in the review suggested that a healthcare environment should be provided that empowers the LGBT parent to disclose their sexual orientation. However it could be argued that placing posters on the wall and offering leaflets to verify an LGBT 'friendly' environment are not effective by themselves, as a poster alone cannot alter personal attitudes. Therefore the most worthwhile use of resources would be to ensure

that all staff had received appropriate training in LGBT issues and challenges faced in healthcare by LGBT people (Chapman *et al.*, 2012a; Shields *et al.*, 2012; Wells and Lang, 2016; Andersen *et al.*, 2017; Goldberg *et al.*, 2019).

The overall themes determined by the literature review will now be discussed.

2.7.1 Attitudes and managing healthcare experiences

Assumptions of heterosexuality with heterosexist language used within the health consultations and also a failure to recognise the non-biological parent were challenges endured by the participants in all except for one of the studies (Goldberg *et al.*, 2019) as they attempted to navigate their way through healthcare. Perrin and Kulkin (1996) divulged that their participants felt that some healthcare providers lacked an acceptance and/or knowledge and understanding of same-sex parents and they frequently needed to remind the provider that both partners were the child's parents (40% of a sample size of 255 participants based in the USA suffered exclusion of the non-biological parent during consultations). This was also a feature of the studies by Malmquist and Zetterqvist Nelson (2013), Andersen *et al.*, (2017) and Kerppola *et al.*, (2019), which were based in Sweden, Finland and Sweden with sample sizes of 96, 14 and 22 respectively. Perrin and Kulkin (1996) found some children had received inappropriate diagnoses based upon the assumptions by practitioners about the family dynamic, including one infant who the paediatrician believed was failing to grow appropriately due to being confused at having two mothers. In the Australian study with 11 participants conducted by Chapman *et al.*, (2012a) a transgender parent reported that healthcare providers often had little awareness of how to engage and/or refer to the transgender parent; this is also acknowledged as a concern by some lesbian

and gay parents, however some found it easier to manage this type of indirect discrimination than others and they perceived that this could be due to their own resilience having overcome previous life experiences. The lesbian and gay (LG) (n=78) participants in the study by Goldberg *et al.*, (2019) did not discuss any heterosexist behaviour exhibited by their paediatricians, but accounted for this due to the parents actively searching for an LGBT or LGBT ally⁵ paediatrician to provide medical support for their children. This finding was not observed in any other study.

Very few respondents in all of the studies felt that they had experienced overt homophobia (although no definition of overt discrimination was provided). However they did express that the discrimination that they had been subjected to centre around being asked excessive and evasive questions, including participants (sample size of 21) in Rawsthorne's (2009) Australian study being questioned about the child's family of origin and the current family dynamic. This is further endorsed in Malmquist and Zetterqvist Nelson's (2013) Swedish study with 96 participants and Appelgren Engstron, Borneskog and Almqvist's (2019) study based in Sweden with 20 participants, which detailed how two mother families felt that they had to justify their family structure when encountering healthcare professionals.

The findings on attitudes and management of healthcare experiences have altered dramatically from the first chronological study (Perrin and Kulkin, 1996) being reviewed to the latest available study focusing solely on LGBT parents (Kerppola *et al.*, 2019), which could be as a consequence of the evolution of

⁵ 'ally' is a term used to describe 'heterosexual people who believe that lesbian, gay and bisexual people should experience full equality' (Stonewall, 2011. p2)

social systems and acceptance/tolerance, although given the small sample sizes and varying localities, this should be considered cautiously. All parents in the studies that alluded to concerns over attitude and managing healthcare experiences, described utilising strategies of protection and presenting a united front in the presence of their children in order to protect their children by validating their family dynamic.

2.7.2 Acknowledgment of sexual orientation

Acknowledgment of sexual orientation is a theme that features significantly in all of the studies. This theme is associated with disclosure of sexuality, and how LGBT persons manage their level of disclosure or 'outing' will vary for each individual parent and is often shaped by their previous life experiences (Chapman *et al.*, 2012a). In Perrin and Kulkin's (1996) study, 77% of parents stated that their child's paediatrician knew if they were lesbian or gay. Of this 77%, 96% of the respondents commented that they had made a point to tell him/her, whereas 4% were directly asked by the paediatrician. Of the 23% of parents whose paediatrician did not know their sexuality, approximately half would have preferred them to know. The earliest study (Perrin and Kulkin, 1996) from the USA was undertaken prior to any States allowing same-sex marriage or the adoption of children by same-sex couples, with same-sex relationships not being protected under federal law within the USA until 2015. This study found that parents who did not wish to disclose their sexuality were more likely to report negative experiences in healthcare. In contrast, the demographics of the study illustrated that those women with a high level of education and young children and whose healthcare provider identified as lesbian or gay had the highest reporting score of disclosure. Overall the study found that parents who did not disclose their sexual orientation had a strong

belief that if they did, their children would be viewed differently and their care compromised due to concerns over confidentiality (Perrin and Kulkin, 1996). This concern is also supported in the work of Mikhailovich, Martin and Lawton (2001) which originates from Australia (whereby same-sex relationships were not legally recognised as de facto⁶ until 2009). However, many respondents (n=92) felt that their family constellation had many strengths and that paediatricians should be aware that the children are not deprived, they are wanted children and that the role of the family is similar to that of a nuclear family whereby there is a mother and father. The emergence of recognition of family constellation (Malmquist and Zetterqvist Nelson, 2013) and same-sex parental roles mimicking that of a 'societal norm' of a nuclear family is also echoed in the work of Kerppola *et al.*, (2019) who determined that acknowledgement of sexual orientation by healthcare professionals and empowerment of parents to define themselves as LGBT aided in them being recognised as co-parents.

Mikhailovich, Martin and Lawton (2001) found that despite LG parents demonstrating high levels of satisfaction with their care, 49% of parents were fearful of disclosing their sexuality to their child's healthcare provider as they were concerned that it may affect the treatment their child received and that they, the parents, may be subjected to judgmental attitudes and/or homophobia. Other parents were unsure as to how to disclose their sexuality and if it was relevant, although 76.6% of parents in the study had disclosed their sexual orientation. Mikhailovich, Martin and Lawton (2001) reported on various factors

⁶ A de facto relationship is one where two adults live together as a couple (Family Law Act, 1975).

which had been identified by parents as pivotal to their self-disclosure, these were believing that it was relevant to the care of the child and also a political statement and commitment to being 'out' as LGBT. These two factors were then inextricably linked to being open and honest with the child to ensure that the child saw their family constellation as 'normal' and therefore to improve the relationship with the healthcare provider through honesty and openness (Mikhailovich, Martin and Lawton, 2001). The majority of participants in the study found that honesty and openness enabled the partners to be intrinsic to the consultations and therefore allowed for a sharing of information and an increase in value of the role of the co-parents and to reduce the stigma associated with same-sex couple relationships and parenting. This is further supported by McNair *et al.*, (2008), Rawsthorne (2009), Andersen *et al.*, (2017), Appelgren Engstron, Borneskog and Almqvist, 2019, Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019) who ascertained that positive experiences were achieved in healthcare when parents were open about their relationship and their relationship to their children. Another aim noted by McNair *et al.*, (2008) was the parent's wish to protect their children. That protection, as highlighted by McNair *et al.*, (2008), could have been through non-disclosure and therefore being 'silent' and intentionally physically excluding a parent from a consultation. This could be seen as an avoidance tactic so as to protect the child from realising societal discrimination. Alternatively the parents could present as a 'proud' disclosure whereby a united front was portrayed therefore reducing the confusion of the healthcare provider with regards to family constellation (McNair *et al.*, 2008). Ultimately the findings showed that the participant's main priority was their child's comfort and therefore their decision whether or not to disclose their sexuality was guided by their personal views (McNair *et al.*, 2008).

The study by Chapman *et al.*, (2012a) discussed the acknowledgement of the relationship of the parents, rather than acknowledgement of sexual orientation, and found that whilst some participants had a positive experience with non-judgmental health professionals, there were still some instances whereby their disclosed relationship status was not accepted and one couple was told 'we don't cater for people like you, you're not a family' (Chapman *et al.*, 2012a, p.1131). However, some participants stated that their relationship and family dynamic not being acknowledged is now a thing of the past. Kerppola *et al.*, (2019) also focused on parental relationship and empowerment. They highlighted the importance of being visible and recognised as both a LGBT person and a parent in the healthcare setting. Participants felt that this visibility allowed them freedom and the opportunity to perform their role as a parent by actively caring for their child, although they felt that the healthcare practice routines were planned for heterosexual coupled parents (for example, the use of heteronormative assumptions during conversations) and so this restricted them and made them feel marginalised.

2.7.3 Bureaucratic representation

The rhetoric of institutional forms and documents can be rather telling with regards to the attitudes of the establishment, and prior to legal reform all forms within healthcare were copied and replicated with a traditional societal relationship in mind (Chapman *et al.*, 2012a). It is acknowledged in the research (McNair *et al.*, 2008; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Kerppola *et al.*, 2019), and not country specific, that the bureaucratic systems employed within healthcare are inflexible and outdated as they do not take into account correct recognition of gender and family make-up. The same is true for parenting classes as they request the

name of mother and father in order to secure attendance (Appelgren Engstrom, Borneskog and Almqvist, 2019). In the study by McNair *et al.*, many participants felt that navigating the bureaucracy of the healthcare system was a challenge and it was mostly related to the non-recognition of the existence of lesbian-parented families on documentation as there was not 'a box they fit into anywhere' (2008, p.97). This was illustrated further as LGBT parents lacked representation on data-collection forms (Malmquist and Zetterqvist Nelson, 2013) and confusion by the healthcare professional over whether the non-biological parent could consent to medical treatment (McNair *et al.*, 2008). These findings were not country specific and were still apparent in the more recent studies, undertaken in Sweden and USA, despite an increasing social and legal acceptance of LGBT headed families. Numerous study participants (Mikhailovich, Martin and Lawton 2001; McNair *et al.*, 2008; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) cited their frustration that their family constellation was not recognised within bureaucracy and whilst in some government departments forms have been altered to acknowledge 'partner 1' and 'partner 2', it is widely admitted that the various health systems still use 'mother' and 'father' in their forms and when making assumptions of heterosexuality when conversing with families. Male participants in one study discussed how they took it in turns to cross out mother and put the other parent in (Chapman *et al.*, 2012a). Mikhailovich, Martin and Lawton (2001) pointed out that their participants felt that the language used in consultations should be more inclusive to LG parents and that medical documentation should not assume that people are heterosexual and should not insinuate that the only legitimate family type is the nuclear family. This finding is supported by Chapman *et al.*, (2012a) and

Kerppola *et al.*, (2019). Andersen *et al.*, (2017) provides additional dialogue by highlighting that same-sex parents are marginalised within healthcare due to the heteronormative language utilised on the health care forms, although provides comment that some parents found that their healthcare provider was respectful of them from the beginning and made a point to use the correct vocabulary (such as partner) and to not assume heterosexuality. This is further acknowledged by Appelgren-Engstrom, Borneskog and Almqvist (2019). However this could be seen as a relational attempt by the healthcare professional to overcome institutional bureaucratic discrimination. The overall aim with regards to transforming bureaucracy is that it should be implemented to enhance the environment and make it more supportive for LGBT parents (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; Andersen *et al.*, 2017; Kerppola *et al.*, 2019). It is suggested that this could be achieved by using gender neutral terminology such as 'parent' or 'partner' to avoid the assumption of universal heterosexuality, and forms should be inclusive of diversity. This finding is also expanded upon by Goldberg *et al.*, (2019), but exclusively considered in relation to adoptive parents due to the scope of the study. The participants, regardless of their sexuality, commented that adoptive families should feel that their child, family constellation, and their medical conditions should be viewed through an adoption lens as this would ensure adoption competence and would allow for an inclusive health consultation.

One additional area of transformation alongside inclusive documentation acknowledged by most of the studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and

Almqvist, 2019) is that if basic alterations were made to clinic and hospital areas such as public displays reflecting family diversity and utilisation of non-gendered terminology, this could, through the use of symbolic acceptance, aid in the acceptance of LGBT parented families in healthcare settings and wider institutions, such as education, and LGBT parents may feel more supported.

2.8 Summary

Due to there being a lack of literature from the UK, it is recommended that LGBT parents' experiences in accessing healthcare services for their children in the UK are ascertained, which in part is what this study seeks to do. Alongside this it is also important to gain awareness of LGBT parents' experiences when accessing healthcare services for their *adopted children* due to the increased vulnerability and challenges of adopted people with regards to their identity (Bramlett, Radel and Blumberg, 2007; Mellish *et al.*, 2013; Goldberg *et al.*, 2019). The specific group of LGBT adoptive parents accessing healthcare for their children is minimal in the current literature (Goldberg *et al.*, 2019); given their vulnerability on account of sexuality and differing route to parenthood, this evident gap needs to be addressed. The views of the children whose parents are LGBT are also important in how they perceive the health consultation, however this is beyond the scope of this study.

Healthcare institutions and professionals have a moral duty to improve the health environment by implementing strategies such as inclusive environments and engagement of LGBT communities whilst improving education surrounding LGBT issues. It can be deduced from the literature review that whilst parental satisfaction has increased with regards to LGBT parents accessing healthcare

services for their children over recent years, there remains rhetoric of normative heterosexism within institutions and thus non-inclusive environments. This in itself could prove challenging for both LGBT parents and their children as they navigate their way through a system whilst feeling the need to define and normalise their family constellation and therefore justify their identity.

The main barriers for the reviewed research is that the topic of LGBT is sensitive and there remains stigma associated with the label (Hacking, 2000) in many parts of the world and indeed various communities. Therefore some families who may have been able to provide data have chosen to remain 'silent'⁷ or 'invisible' to the investigators. There is also a lack of LGBT parents included in the data who do not have a graduate degree. It could be deducted that the demographic with a degree level education, has both the assertiveness and life skills to successfully negotiate the healthcare system for their children (Shields *et al.*, 2012). Different results may have been gained if more vulnerable LGBT families (such as those suggested above) had participated in the studies, as these families may have required additional health and social care support, education for themselves and potentially an advocate in healthcare settings (Shields *et al.*, 2012; Kerppola *et al.*, 2019).

2.9 Research aim and questions

The review of the literature has identified what is already known about this subject area, and has therefore helped shape the research questions and methodological design of the study (see Chapter 3). The overall aim of this research study was to explore the experiences of lesbian parents when accessing healthcare for their adopted children. By doing so it is hoped that the

⁷ A 'silent' or 'hidden' LGBT person is someone who has not disclosed their sexual or gender identity to others except for themselves.

findings will inform and shape the English health service to ensure that the needs of lesbian parents and their adopted children are met.

Therefore the following research questions were posed;

- 1) How do lesbian parents describe their experiences of healthcare consultations for their adopted children in England?
- 2) How is the family unit acknowledged within the healthcare journey?
- 3) What are the perceptions of lesbian parents of accessing healthcare for their adopted children?

The following chapter will provide an awareness of the philosophy underpinning my study and will also detail the methodology utilised to respond to these research questions. These choices were made with a specific focus on how the voices of lesbian parents accessing healthcare for their adopted children are enabled and heard.

Chapter 3 - Methodology

3.1 Introduction

This study is a small scale qualitative piece of research, using a Narrative Inquiry approach with the aim being to hear and amplify to the wider audience, lesbian parents' personal accounts of accessing and receiving healthcare in England for their adopted children. This chapter seeks to provide an awareness of feminist and queer philosophy which serves as the theoretical framework underpinning the methodology of this study. The research methodology of the study is outlined including discussion of the research paradigm, using Narrative Inquiry through interviews as the method, the use of Skype as a data collection tool and the recruitment strategy. The pilot study is discussed followed by the process of interview transcription and the employment of narrative analysis tools to analyse the data. Finally ethical considerations for the main study are considered. Incorporated into this chapter is the development of a composite character couple and the rationale for this inclusion.

3.2 Philosophical underpinning of the study

To understand the study aims, it is important to realise the paradigm and the rationale for the approach taken. Epistemology is the philosophical study of theories of knowledge, and the epistemological position is fundamental to both me (the researcher) and to my audience, for the positioning that I take lends itself to defining the person that I am within that given moment of time (Frank, 2011). Ferrier (2009) defines epistemology as the science of origins of knowledge which includes philosophical method, which is recognised as a framework that can answer all questions about human life (Haug, 2013). Therefore it is my understanding that epistemology is the theory of nature and

the grounds of knowledge with particular attention paid to its limits and validity (Audi, 1998; Morse, 1994). Epistemology is entwined with ontology, whereby the nature and relations of being are realised, however the end result is not always clear and is rarely pre-empted (Morse, 1994). I can therefore deduce that ontology is regarded as 'reality' and epistemology as 'the relationship between that reality and the researcher'.

When considering my own positioning, it was important that I had a rounded knowledge base of the various epistemological positions. Positivism is a well-established epistemological positioning in which the research aims to produce objective knowledge uncontaminated by the views of the researcher or bias (Willig, 2008). Within the field of natural sciences, the positivist approach has been used widely and successfully. However the field of social sciences and in this situation, the field of health and wellbeing, does not lend itself easily to the positivist approach as I, the researcher, have some influence over the project. Human behaviours and perceptions may be affected by both myself as the researcher and the participants taking part in research. Historically researchers have attempted to apply positivist approaches to social science, however it is often inappropriate to adopt this approach as society and human behaviour does not operate according to laws in the same way that the physical world functions based upon the law of gravity (Comte, 1848 in Macionis, 2012). Therefore, if research is undertaken by a human being and has people as its focus, it has to consider that people have their own perceptions, thoughts, feelings, beliefs and wishes which may have an effect on the questions asked, the adopted methods of obtaining and analysing data and may also have an influence on the research findings.

Exploring the juxtaposition to positivism; a consideration of research approaches based upon a relativist epistemology concludes that the only reality that exists is related to human consciousness (Scotland, 2012). Adhering to this opinion, the focus of any research activities involving human participants **should** be towards peoples' perceptions of life events, in all their subjectivity, to infer the meanings that people have discovered within their life. Relativist approaches view naturalistic discourse methods in equal measure to positivist methodology and also stress the importance that language has, as an object of study (Scotland, 2012). Moreover, post-modern ideals conclude that reality is individually constructed and the linguistics that are utilised seek to sculpt and form the objects within reality, rather than label them (Frowe, 2001; Scotland, 2012), therefore the reality is fashioned via the communication between language and the world that surrounds us. This awareness of language was further acknowledged by the linguistic turn, as discussed in chapter 1. This period of time thus enabled the world to be viewed differently, as instead of relying on empirical data, the meaning of objects could be gained through their representation and interpretation (Saussure, 1916; Foucault, 1978; Butler, 1990). As I am a children's nurse, this increased knowledge further whetted my appetite as 'a day in a child health environment' is constantly changing dependent on what is said, by whom and in what context – altering a conversation to be understood in the setting dependent on whether you are speaking to a child, parent or professional.

Furthermore, in addition to dwelling on these assumptions, the positioning of social constructionism was also of fascination as it lends itself to the critical paradigm as the ontological assumption of the paradigm is that of historical

realism and the discourse of seeing people as multi-faceted parts versus seeing people as a whole (Hacking, 2000; Hacking, 2010; Scotland, 2012). Historical realism is the understanding that the reality which we face is one that has been moulded by gender, economic, social, cultural, political and ethnic values and is therefore socially constructed (Cresswell, 2007; Scotland, 2012). There is a belief that knowledge is socially constructed and that we are born into a culture as the world that we enter when we are born already has meaning within it. It is our culture that adds to the meaning of the world as we are not just in the world, we are also with it. Therefore reality can be altered and it is an ever changing state (Foucault, 1978; Baudrillard, 2005). This is further endorsed by my professional position as a children's nurse, as a child's clinical condition can be constantly changing and every day presents a different child and family with a differing condition. This in turn further links into my study, as the study considers how healthcare professionals react and interact with different children, parents and different combinations of conditions and the meaning that the participants draw from this.

3.3 Theoretical frameworks underpinning the study

Being a woman and also carrying the additional intersectional layers of identifying as a lesbian and an adopter, I am part of a marginalised group. These intersections, in isolation, can lead to discrimination and oppression, however when combined, the effect of layering increases the incidence of oppression (McCann and Monaghan, 2020). Duality can exist within marginalized groups due to their integration within both an institution such as the NHS and broader society. Duality also pertains when acknowledging that when in the environment of their own subculture or their own 'community', a marginalised group from broader society often ceases to be marginalised in this

setting as they are the majority, not the minority (Formby, 2013). Therefore I am aware and have also endured marginalization and labelling within society, which can be stifling, and may lead to people's experiences and perceptions being untold (Hacking, 2000). With this in mind the theoretical frameworks that underpin the study are both feminist and queer theory (see 3.3.2 and 3.3.3). Application of feminist theory throughout this thesis may help to question underlying assumptions within healthcare, as feminist theory is a group of critical theories (which incorporates a movement onto queer theory) and approaches that enable us to understand complexity, power, patriarchy and structural practices (Sharma, 2019).

3.3.1 Understanding the social construction of gender and heteronormative culture

This study sought to value the voices of lesbians, who can be considered to be a marginalized group on account of their gender, sexual orientation and a deviation from the socio-cultural 'norm' (Benhabib, Butler, Cornell and Fraser, 1995) within British society. Due to the assumed normative of heterosexism in healthcare (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Kerppola *et al.*, 2019), this study combines feminist and queer theory to provide an analytical lens with which to expose the norms of the health care system and the implications of that for the families being researched. Feminism provides the springboard to further engage with and apply queer theory to the study and they are both entwined as two philosophical standings allowing for the illumination of the experiences of the women in the first instance, before the experiences of lesbians are illustrated due to the inclusion of queer theory.

3.3.2 Feminist theory

Feminism is a compilation of principles and actions that occupy the same goal, which is to define, establish and defend equal rights for women in relation to politics, economics, culture and social status (Butler, 1990) by shining a light on the social construction of gender and gender roles and the consequences and implications of that for society and people's position within society. The theory of feminism has developed from feminist movements dating back to the Suffragettes in the late 19th and early 20th century during the first-wave, up to and including third-wave feminism (postmodern) which recognises intersectionality and includes queer theory and multiple ethnicities of females (Burr, 2003). Postmodern feminists established the understanding that in western civilisation women were not subordinate to men, as perceived by Simone de Beauvoir (Simons, 1995). Butler (1990) noted that gender does not define who we are as it is merely a linguistic term placed upon men and women by society and that men and women are all equal. However, we live in a society which is structured based upon gender (binary) coding, therefore whilst we may not agree with gender labelling, in current British society it is the constructed norm. However it is no longer a rarity for a woman to be a mechanic or a man to be a childminder, neither is it uncommon for both parents to work full-time, for someone to be a single parent or for a child to have two fathers or two mothers (Mellish *et al.*, 2013). Therefore gender and its historical context has been changed due to the continuously changing reality in which we live (Benhabib *et al.*, 1995; Burr, 2003). Current reality therefore allows us to develop a discourse surrounding the gender role and enables the deconstruction of traditional male and female roles due to changes in family dynamics (Clarke, 2007). Gender roles are socially constructed (Burr, 2003) as they are ascribed

to the role that a person performs based upon their gender and the associated masculine and feminine capabilities and attributes applied to what it is to be a 'man' or 'woman'. This limiting stereotyping can affect people's lived experience and their own behaviours as well as leading to discrimination and oppression at a personal, cultural and societal level and this ensures that men, in a patriarchal society, have power and privilege over women. A gender stereotype is a broad view or assumption about the characteristics, attributes or roles ascribed to a gender and they are harmful as they can restrict the capacity of a man or a woman to progress their own personal abilities and/or make their own life choices. An example of this type of assumption is that men, unlike women, are not as easily influenced by their emotions (OHCHR, 2014). This dialogue of gender roles allows for the emergence of a discourse surrounding gender stereotyping which is prohibited under the international human rights law framework (OHCHR, 2014) as it undermines the enjoyment of human rights and fundamental freedoms. United Nations states (which includes the United Kingdom of Great Britain and Northern Ireland) have an obligation to eliminate discrimination against women and men in all areas of their lives (Gifkins, Jarvis and Ralph, 2019).

Following on from gender stereotyping, a further discourse entwined through feminism is the contested nature of female vulnerability (Stemple and Meyer, 2014). An argument within this discourse highlights that due to the feminist movement progressing into the third wave (post-modern) and the notion that, on an intellectual level, gender does not exist due to its social construction, it could be construed that neither women are more vulnerable than men or vice versa; however, society is not gender normless, therefore some people within societies

will subscribe to gendered vulnerability. In addition it also does not signify that women believe that they have a higher level of vulnerability than men do (Butler and Gambetti, 2013). It does however indicate that specific types of gender-defining attributes, such as vulnerability and invulnerability, are unequally distributed and are utilised to support power regimes which disenfranchise women (Butler and Gambetti, 2013).

Historically, feminism has been associated with gay women or lesbians (Cochrane, 2012) however it should be recognised that feminism is a political and philosophical movement, and not concerned with sexual orientation (although through my formative years I was scared of identifying as a feminist, as I believed that it would automatically 'out' me as being a gay woman).

However my increasing awareness of the feminist existentialist philosophy and cultural movement of Simone de Beauvoir (Simons, 1995) provided a correlation between her thoughts, mine and others; ultimately thinking begins with an individual and the experience which they are exposed to. Therefore we are all responsible for the choices that we make as it is important to remain true to our being whilst also acknowledging moral thinking (Simons, 1995; Cochrane, 2012). However, cultures operate with an unconscious level (including an unconscious bias in relation to gender and other intersections such as race and sexuality) which obscures people from seeing the varied underlying influences which construct their identities and therefore affects their behaviours towards self and others. As individuals we will engage in relationships with other people or other things within their surroundings, these relationships will all enrich or curb the choices that are made by us (Simons, 1995). Throughout the writing of this thesis I have maintained a stance of being a postmodern feminist as I challenge the notion of gender and therefore the

perceived gender stereotyping role of 'mother' and 'father', as gender is a social construction and the historical and cultural experiences of women cannot be generalised (Butler, 1990; Burr, 2003), yet must be acknowledged with regards to how a family unit and an all-female parented family is received within English healthcare. As such, the findings of this study also cannot be generalised as they are embedded within Narrative Inquiry and therefore consider the experiences of the individual and couple participants.

3.3.3 Queer theory

Correlated to third-wave feminism and further challenging the concept of gender is queer theory. Queer theory, historically, has been difficult to define (McCann and Monaghan, 2020) as the term 'queer' is seen as an ambiguous term and if one were to define it, then being tied to a definition would be converse to the theory. Queer theory goes much further than questioning the foundations of sexual identity (McCann and Monaghan, 2020), it creates a dialogue surrounding all intersections which include race, gender, class, ethnicity, disability and citizenship, and therefore it is expansive. A key concept in queer theory is the notion of heteronormativity which refers to heterosexuality as 'the institutions, structures of understanding, and practical orientations that make heterosexuality seem not only coherent—that is, organized as a sexuality—but also privileged' (Berlant and Warner, 1998, p.548). Therefore heteronormativity is a viewpoint associated with the promotion of heterosexuality as the 'norm' or preferred and assumed sexual orientation and this is further reinforced within some worldwide societies through the institution of marriage, adoption of children laws and bureaucracy within healthcare and education (Stonewall, 2008). Heteronormativity can be seen as an example of enfranchisement and power through perceived accepted social norms and institutional (the

institutions of both the National Health Service and family) arrangements. It can be deduced that heterosexuals are privileged and recognised by institutional arrangements including institutional processes and symbolism (such as administrative forms and imagery – see 2.7.3), people's preferential attitudes and up until recently, the law.

Under the umbrella of queer theory, consideration of the existence of micro-aggressions is also worthy of note. Micro-aggressions emerge out of prejudice and discrimination and result in oppressive practices such as everyday hostile or derogatory behaviours and statements which may be consciously or unconsciously delivered (including banter within a culture), ordinarily to members of targeted minority social groups such as LGBT people; people of differing skin colour; women; stigmatized religious groups (Sue, 2010). As a result of micro-aggressions, minority stress (Meyer, 2003) may also be felt by member of the minority group due to the relationship between minority and dominant values and resultant conflict within various environments, for example, in relation to this study, the healthcare environment. The theory of micro-aggressions was introduced in the 1970s and was related to racial micro-aggression, this has now spiralled to include other marginalised groups and has been found to be causally related to mental health issues due to the cumulative effects of subtle prejudice (Farr, Crain, Oakley, Cashen and Garber, 2015; Nadal, Whitman, Davis, Erazo and Davidoff, 2016). Micro-aggressions are an important awareness point within my study as the more intersections ascribed to a person (for example woman, lesbian, parent, person of colour) the higher the incidence of micro-aggressions (Nadal *et al.*, 2016). Therefore if the participants had encountered micro-aggressions through, for example, inappropriate terminology utilised in healthcare or assumptions made such as

being asked 'who plays the part of Dad?', then there will be a negative emotional impact on the lesbian parent as this type of comment is entrenched in hetero-normative culture, attitudes and institutional arrangements, thus maintaining that the only 'viable' family construct contains a mother and a father and not same-sex parents. This type of discriminatory question and terminology draws the thread of intersection between gender and role and is an example of both gender role stereotyping as proposed by feminist theory and heteronormative discrimination which stems from queer theory. Therefore these micro-aggressive assertions led me to explore the experiences of lesbian parents when accessing healthcare for their adopted children, due to the intersectional play of the participants' identities.

3.4 The route to Narrative Inquiry

When the doctoral journey commenced, wide reading around autoethnography developed a desire to provide a reflexive self-narrative which explored my own lived experience and interconnected it with wider social, cultural and political meanings (Chang, 2009). Ethnography falls under the umbrella of Narrative Inquiry which would allow an expression of ideas. However as time passed and academic supervisors provided comments there was a deviation away from autoethnography and a favouring of Narrative Inquiry and utilising the stories of others, rather than self, as I had intrinsic concerns whether 'my story' and my voice would be powerful and too exposing on its own. Narrative Inquiry remained suitable to meet the research aims as it would enable me to listen to and embrace other people's retrospective narratives and then I could capture their experiences over a given time and interpret them.

Bruner (2004) deduced that differing types of qualitative research can provide the researcher with idiographic data which can be explored and analysed and thus meaning can be given to the individual or communities' life. The use of language is vital in understanding individuals' lives and interactions (Frowe, 2001; Bruner; 2004; Scotland, 2012) as it allows stories to be told and interpreted. Narrative Inquiry is a suggested differing research methodology as it considers the relationship between the experience that the individual has encountered and the cultural context of it (Clandinin and Connelly, 2000). Research embedded in narrative is not an exact imitation of an event or experience, but it can be utilised to aid in the creation of reality and to make sense of events for the individual person; however it is not the search for uncomplicated truths (Atkinson and Delamont, 2006). Clandinin and Connelly (2000) and Montello (2014) comment further that the umbrella term of Narrative Inquiry and storytelling allows the researcher and the participant the chance to interact and thus become aware of incidences and values that matter to the participant or participant and researcher, and to contextualise them in relation to the social, political and cultural environment. John Dewey's pragmatic philosophy (Dewey, 1925; Dewey, 1934) inspired Connelly and Clandinin's (1990) development of Narrative Inquiry based upon a view of human experience as the three dimensional principles are built upon interaction (personal and social), continuity (past, present and future) and situation (place), therefore the narrative structure is three-dimensional. Dewey's (1934) approach indicates that in order to understand human beings, it is important to explore their personal experiences and also their interactions with other people. Dewey's approach alongside Connelly and Clandinin's (1990) adaptation therefore has a strong influence on this study and the utilisation of Narrative

Inquiry within it as the participant storytelling is fluid in nature due to its shifts from past, to present and then consideration for the future, whilst also incorporating the varying interaction with healthcare professionals and the settings in which they occur (Wang and Geale, 2015).

Narrative Inquiry can take several forms with various methods of data collection, analysis and representation being utilised (Trahar, 2008), therefore the methods being used in the study must be made explicit as Narrative Inquiry can be considered an 'amalgam of interdisciplinary analytic lenses, diverse disciplinary approaches, and both traditional and innovative methods' (Chase, 2005, p.651). With this in mind, Narrative Inquiry is not solely concerned with collating participant stories and retelling them; adopting a narrative approach is recognising that the umbrella of narrative accept that data, analysis and representation are all narrative in form (Conle, 2000). Narrative Inquiry allows a participant's voice to be magnified so that it is heard, rather than remaining silent or muted, as it allows communication of participants' realities through storytelling, thus projecting the participants' voice to a much larger audience (Reissman, 2008; Trahar, 2013). When presenting findings, the employment of narrative allows researchers to open up deep strata of information which provides an extensive awareness and understanding of the experiences and perceptions of the participants involved and 'living in' their story, albeit as viewed by the researcher (Wang and Geale, 2015). Knowledge that is gained from Narrative Inquiry can allow the reader a much broader and plentiful understanding of the subject discourse and may afford the opportunity to apply the participants stories to the readers own historical, political and/or social context. Therefore it can be deduced that narrative allows human beings to be

'lit up' and their stories shared with meaning and contextualisation ascertained. This is echoed in the work of Vygotsky (1978) as when a human being tells their story, their thought is exposed, but the 'thought' endures a multitude of alterations before its' form is altered into speech. The 'thought' does not only discover expression in speech; it finds reality and form. This determination of reality confirmed the methodology of Narrative Inquiry for this study.

3.4.1 Applying Narrative Inquiry as the methodology for this study

I sculpted the study as a Narrative Inquiry, in which narrative was both the phenomenon to be explored and the method of inquiry (Connelly and Clandinin, 2006). This study is consequently framed within the interpretivist paradigm. Therefore its' focus is on the way that human beings attach meaning to the subjective reality of their experience that they have attempted to make sense of (Mertens, 2005; Bryman, 2008). Different people will hold varying truths dependent upon how they make sense of the world and how they cast judgement. Narrative Inquiry holds no certainty and seeks to explore the meaning of interactions and not necessarily to establish the truth of the events (Webster and Mertova, 2007).

As a method, Narrative Inquiry associates with social construction, feminism and queer theory due to how a culture can shape the person that we are (Foucault, 1969; Foucault, 1978; Butler, 1990). Narrative Inquiry aligns itself to social construction ideations that there are multiple realities and that no single truth exists as realities are both personally and socially constructed (Burr, 2003). Therefore people will perceive events differently to one another due to their socio-cultural norms and also the meaning to which they ascribe to various words and terminology (Frank, 2011). Stories and narratives can arise in many

modes such as oral, written or pictorial (Riessman, 2008) and whilst there are various opinions relating to these differing modes, this study centres on the employment of Narrative Inquiry with purposefully constructed verbal stories. This study applies this style within a series of interviews and then further endorses it through the creation of a composite character couple (see 3.8.1) and the 're-storying' technique (see 3.8) which allows for the method of Narrative Inquiry to be used as both a way of gathering and presenting data.

In relation to this study, I wanted the voices of the participants to be understood in context to the wider socio-cultural environment (and their identities within that) in which their critical events took place, as they are also significant of specific socio-historical phenomena in which their biographies are embedded. The stories were sought from couples (or people who were part of a couple) as this stance acknowledges that each story has multiple voices and varying perceptions due to the multiple realities that each participant encounters and how their stories are interwoven (Connelly and Clandinin, 2006). For the purpose of this study, the term 'critical incident' was obtained from the work of Webster and Mertova (2007) and was given to mean a snapshot of something that happens to a patient or their family; it could be something positive, or it could be a situation where someone has suffered or been challenged in some way (Rich and Parker, 1995). An additional belief of this study is that the participants will co-construct their narrative with me, the researcher. I explicitly told the participants during the first interview that I am a lesbian adopter with my own experiences of taking my children to healthcare appointments. Therefore this provided me with an additional layer and nuance to my interaction with the participants and this aspect of the study. By sharing stories of the experiences

of the participants in this study it was felt that issues may become evident which the participants (parents) did not necessarily react to at the time, but which through dialogic engagement with me, the researcher, might reveal new insights, needs, practices, and the emotions and feelings accompanying the experiences of accessing health care services on their children's behalf. In addition, due to my permanent presence in my own research, as a lesbian adopter, I am classed as an 'in-dweller' (Greene, 2014). This, therefore, provides an exclusive opportunity to reflect on how my positioning affects my interaction with the participants, the data that is collected and its method of collection and interpretation. The stories that were told by my study participants and how I chose to represent and share them are unsurprisingly sculpted by my own understanding and positioning within their (and my own) social world (Greene, 2014). My own story was told separately and not shared with the participants until the third interview, at which point the data had been analysed and remained unchanged. Therefore whilst they were aware of some of my background, it was only in relation to my positioning and not my own critical incident discussion, thus reducing the interference of my story with theirs. My experience undoubtedly had influence over the interviews, questions and interactions with the participants, due to me being an in-dweller.

Establishing and maintaining an appropriate degree of both social and emotional distance from the participants was not an easy feat due to the rapport that I had built up with them. Nonetheless, it was vital that I recognised the interplay between the participants and my own multiple social locations and experiences and how these intersected with their own stories within the realm of Narrative Inquiry (Mauthner and Doucet, 2003). As this study utilised the method of Narrative Inquiry and insider, 'in-dweller' research with reflexivity, my

own story provided data which was included in the findings. There were differences and also commonalities between mine and the participants' experiences but I ensured that I bracketed my experiences and also did not consciously influence the storytelling of the participants. Therefore it should be recognised that this study, true to the nature of Narrative Inquiry and self-reflexivity, represents through entwinement, a research biography due to the participants' stories and also an autobiography due to the researchers' story (Van den Hoonaard, 2002).

When considering the participants stories, I did not consciously view their story alongside mine (as my wife and I provided our own critical incident as part of the data gathering process) or make any initial analysis regarding commonalities whilst they were telling their story. It was at the point of transcription that I 're-storyed' the data and determined common themes. Together, our stories then formed part of a composite character couple (see 3.8.1) and were 're-storyed' in the format of Narrative Inquiry, as the narratives were subject to the assumptions, ideas and biases of both me, the researcher, and the participant (Weick, 1995; Frank, 2011). Member-checking was carried out at the third interview and alleviated bias and confirmed that my interpretation was how the participants had intended, therefore I can deduce that I was positioned appropriately to diminish the risk of interference whilst using Narrative Inquiry as a method.

3.5 Data collection methods

Initially the plan was for the couples to be interviewed together (discussed further in 3.6) as it would allow for a discussion of differing recollections, which could lead to a fuller and potentially more accurate depiction of the event by

obtaining richer data of two people's narratives and recollections of the same incidents (Bennett and McAvitty, 1985; Mellor, Slaymaker and Cleland, 2013). The multiple perspectives provided in 'couple' interviews can provide rich data that allows additional stories within couples' narratives, including shared memories (Valentine, 1999). When the couple is interviewed together, an account given by one person in the couple may prompt the partner to tell another story (Allan, 1980). This was an important consideration for this study as I wanted to gain an awareness of the experience of a same-sex couple attending a health consultation for their child/ren.

3.5.1 The interview as a method

The term 'interview' is generally referred to within literature associated with research as a structured event (Webster and Mertova, 2007), however as this study was set within Narrative Inquiry it was important to move away from a 'scripted' interview with specific set questions and to allow the participant to control and 'own' the discussion and their own story (Bold, 2012). An appropriate way to do this was by asking the participant to tell me about a critical incident that had occurred when accessing and/or receiving healthcare for their adopted child/ren. I explained to the participants that critical incidents are snapshots of something that happens to a patient or their family (see 3.4.1). An innovative contribution to the methodology involved utilising a 3 stage interview process, focussed around a critical incident, and then creating a composite character couple, to 'bring to life' the interviews retrospectively through the use of a 're-storying' composition which allowed the conversations of the research to be retold through the composite character (Wiebe, 2014).

The approach to conducting a three stage interview was as follows. The first interview, lasting approximately 20 minutes in length, I introduced myself to the participants and gathered demographic data such as age, ethnicity, locality and occupation in order to gain an understanding of the participants' backgrounds which would ultimately be used to help determine the characteristics of the composite character couple. I also began to develop a rapport with them and I discussed the research and asked them to think about any critical incidents in time for the next stage of the interview process. I told the participants about my positionality as a children's nurse and lesbian adoptive parent who has accessed healthcare for my children, although no details of my experiences were shared in the first and second interview. During this first interview, my self-disclosure provided common ground for rapport and trust to grow but also confirmed my position to the participants so that with this additional knowledge they could determine if they wished to proceed. This information, I believe, facilitated a sense of mutual understanding and facilitated the participants to disclose their experience and they were able to use medical terminology when they wanted to as they were understood by me when doing so.

Following on from the first interview, the critical incident interview was scheduled for approximately one week later (the timings were dependent on the availability of myself and the participants). The only structure to the second interview was asking the participant/s to recall a critical incident and also to ascertain if they had seen any positive imagery around adoptive families within the health setting, the remainder of the interview was unstructured, but with some probing if necessary. The probing questions were related to clarification of points which the participant may have provided when telling their story and also my own curiosity of their story. I believe that it was important to allow them

to tell their story uninterrupted and in the manner that they wanted to.

Therefore they sometimes 'jumped around' with their story as further critical incidents unfolded which they wanted to share and all of the participants discussed more than one critical incident which were a mixture of positive and negative situations. The critical incident interview was scheduled to last for approximately sixty minutes, but this was dependent upon the story that was being told about their experiences. The interview times ranged between 31 minutes and 63 minutes. The mean interview time was 50 minutes. Whilst one interview was only 31 minutes, the story told was in depth and factual.

The third and final interview with each set of participants was held approximately eight weeks after the second interview, once the interviews had been transcribed and analysed. This provided an opportunity to discuss the initial findings and to 'sense-check' that I had interpreted the participants' story in the way that they had meant it to be understood. Sense-making (Weick, 1995) was achieved by retrospectively discussing the social situation whereby the participants reflected upon the critical incidents that they discussed in the second interview and then my sense making was applied to existing literature in the area and discussing it with the participants. The duration of the final interview was approximately 20 minutes and no additional data was provided by the participants at this point. All the participants agreed with the themes that had been determined through their story and two participants stated that the process and my analysis had added more understanding to their experiences, which is the overall aim of Narrative Inquiry (see 3.4).

3.5.2 Skype as a data collection platform, and its enabling nature

Skype (2003) is a telecommunications application which allows people to be connected both audibly and visually. It is a useful tool which enables a participant sample range to be widened due to having no geographical limitations and provided that ethical considerations with regards to confidentiality are maintained, can be conducted anywhere, including from home (Rowley, 2012). Skype interviews were used in this study as they allowed for greater flexibility with regards to fluidity of location, geographical locality of participants and the working hours and parental responsibilities of the participants. Due to its flexible nature one participant couple chose to undertake the Skype interview in the evening once their child was in bed.

The participants conducted the interviews from their own homes, utilising Skype, with the exception of one person who used the telephone as she had a technical issue with the installation of Skype. The use of the telephone in this case had no effect on the rapport and trust, although I recognise that we were not able to have any eye contact compared to the other interviews. I conducted the interviews in a private room which could not be overheard, and I recommended that the participants did the same. I felt that it was important to allow the participants to choose the time of the interviews and for them to feel comfortable in their surroundings so as to aid in the interaction between us (Sivell, Prout, Hopewell-Kelly, Baillie, Byrne, Edwards, Harrop, Noble, Sampson and Nelson, 2019).

All the interviews were audio taped using an inbuilt Skype recorder, or digital voice recorder where telephone interviews had been conducted, which enabled me to listen to each one multiple times during the transcription process. They

were transcribed verbatim using Microsoft Word software which enabled me to be completely immersed in the data and allowed me to develop sensitivity to the issues of importance (Holloway and Wheeler, 2010). Each recording was stored in a coded file on a double password protected computer on the University server.

3.6 Sample and recruitment

Six stories (two couples and two individuals who were part of a same-sex couple as shown in table 8) were gathered. I utilised purposive sampling to recruit the participants, which is a non-probability, intentional selection of participants based on their ability to expose a specific theme, concept, or phenomenon (Robinson, 2014). I initially aimed to interview three lesbian couples who had accessed healthcare for their adopted children. I felt that it was important to recruit people to the study who were part of a same-sex couple, as opposed to single parents, as it is acknowledged that there could be differences in their perception of their treatment and the recognition of their family constellation (Stonewall, 2008). However for the final sample I interviewed two couples (my wife and I were a couple included within the sample and our data had been collected during the pilot study), and two women each of whom were part of a couple but their respective partners were unable to participate in the study. Therefore there was a total of six stories, two stories were told collaboratively by two members of a couple (therefore four stories in total) and two stories had one perspective. However where only one person from the couple was able to take part in the interview, a discussion was held between the two partners prior to the interview to ascertain if the other one had any perspective that they wished to share regarding any critical incidents. Therefore, whilst the partners were not involved explicitly in the study, their

voice was represented through their partner as they had both been present at the health consultations for their child/ren.

Due to me being an insider researcher and to ensure that the interviewing of my wife's and my experiences were not biased on account of my gender and sexuality and the participants' characteristics (see section 3.8.2), we utilised our data as part of a pilot study initially and I acknowledged the application of reflexivity throughout the research and thesis (see 3.8.3) in order to bracket our subjective experiences. By analysing my own data in such detail and through developing my conscience of self by keeping a reflective diary (Appendix 8), this helped to avoid transference of my own experiences and assumptions onto those of my participants.

The population sample was homogeneous in nature due to the inclusion criteria in that the selected participants all had to identify as being cis-gendered lesbians, and have parental responsibility for their children due to the making of an Adoption Order (Adoption and Children Act, 2002), and have accessed healthcare on behalf of their child/ren. They had some differences in relation to age, ethnicity and professional status, however in relation to the inclusion criteria the only heterogeneity that existed was that one participant was not a British Citizen and she also had a biological child in addition to an adopted child. It was made explicit that this study was in relation to her adopted child accessing healthcare in England, she understood and agreed. The participants were sought from members of a British LGBT adoption and fostering charity. Contact was made with this charity via a formal letter requesting that they make contact with their members via electronic mail and online message board to inform them of the study. Any interested people were then requested to make

contact with me and I provided them with a welcome letter and information sheet about the study. Two couples (in addition to my wife and I) and two individuals (who were part of a same-sex couple) made contact and asked for further information. All of them provided written consent to participate (see 3.9.1). One couple failed to make any further contact once they had provided written consent. I emailed them asking if they would still like to participate, however they did not respond. They were then removed from the sample.

3.7 Pilot study

To ensure that the research method and interview question was fit for purpose I conducted a pilot study. Whilst it was initially to be an interview conducted between my wife and I, I decided (with ethical approval) to widen the pilot study and included other participants who were not part of the main study. These participants included a heterosexual cis-gendered couple with biological children, a heterosexual cis-gendered couple with adopted children and a cis-gendered same-sex couple with biological children. The rationale for including the term 'cis' is that in order to ensure identity homogeneity with regards to gender *and* sexuality, it was important that all the participants of the main study identified as lesbian cis-gendered women. The participants in the pilot study all had become parents in differing ways, as detailed above. I made a conscious decision to include the varying routes to parenthood and relationship demographics as I felt that it was important, as part of the pilot, to explore the differences of healthcare (if there were any) in relation to adopted and biologically related children and heterosexual and same-sex couples. The pilot study included another lesbian parent which enabled me to test the critical incident generative question and to recognise any unconscious bias. The generative question was a simple open ended question which allowed for a

story to be told. By utilising the pilot interview process I was able to determine that the question was able to elicit data from participants which could be scrutinised for the purpose of research. From the pilot study process it was evident that new knowledge gained in each interview enlightened me into the role and experiences of the parents (regardless of the family constellation) when accessing healthcare on behalf of their children. Therefore each participant's story allowed a comparison with others, which led to a determination of themes across the data. These included, but were not limited to attitudes and managing healthcare experiences (which spanned across the sexuality, adoption and gender stereotype), and awareness of diverse families. The pilot study was written up, in part, for publication (Appendix 5).

3.8 Data analysis

Narrative Inquiry is a flexible approach and aligned to my own epistemological positioning of social construction. However, whilst it is flexible, having a more 'rigid' framework for data analysis was useful in enabling me to structure and make sense of the collected data. Feminist theory, further applied in chapter 4, was the key lens through which the findings were generated. Thus it may lead to an acceptance of the belief that healthcare access may be improved if assumptions and discrimination based upon gender, race and other intersectionality's are removed from the attitudes, cultures and systems that exist within society.

The data analysis was inductive in that it allowed for the creation of new knowledge and theory as opposed to being deductive and testing a theory (Clandinin and Connelly, 2000). I explored differing models of data analysis, however I decided that a merging of the data analysis tools of Clandinin and Connelly (1990) and Webster and Mertova (2007) would be most appropriate. I came to this decision as combined, these models would allow the acknowledgment of the impact of societal views on people's narratives and the restraints placed upon them in terms of what was an acceptable narrative and what was deemed unacceptable through the lens of feminist and queer theory, which therefore supports the philosophical underpinning of the study in that reality is not objective, and meaning is constructed through interaction with others.

Data analysis commenced during the transcription process and to examine the data I was guided primarily by Webster and Mertova (2007) who offered practical advice and a tool for narrative data analysis of critical incident recall.

The data was manually coded and analysed individually for thematic content and for stories that followed dominant discourses, as well as for stories which did not, but were 'like or other events' to the critical incident (Webster and Mertova, 2007). It is suggested that once the critical incident has been detailed by the participant, it will often lead onto further stories being disclosed. These stories may be 'like events' in that they are similar to the critical incident and therefore lean towards the dominant discourse, or they may be 'other events' and as such, whilst they do not follow the dominant discourse, the new narrative has a discourse which is worthy of being pursued (Webster and Mertova, 2007). Once I had 'grouped' the events I proceeded to adopt Connelly and Clandinin (1990) analytical tools for Narrative Inquiry of *broadening*, *burrowing*, *storying* and *'re-storying'*. To utilise this tool effectively, I considered each transcript individually and for the first tool of *broadening*, I looked for a 'broader' context of the story. This enabled me to make a general description of the participant's character which was information gathered in the first interview and it also considered the social, historical, cultural and/or political environment in which the incident took place. Therefore I was able to '*broaden*' or '*expand*' an awareness of the cultural framework of meaning for the participant and others who would read the study. This enabled me to bring into the analysis any further information that I knew about the participants sharing their stories and their general circumstances (Mishler, 1986; Connelly and Clandinin, 1990). Following on from '*broadening*', it was necessary to begin '*burrowing*' to consider the details of the stories from the point of view of the participants. This involved focusing on more specific details of the transcript, such as the participants expressed feelings, understanding, and certain impacts that the participant may have felt. This involved questioning why and how the events

that were detailed in the participants' stories have influenced their lives. The final component of the analytical process is the combined '*storying*' and '*re-storying*' and this allowed me to find ways, to story and re-story the data so that the experience of the participants was brought to life (and in the case of this study, through the use of a composite character couple (see 3.8.1), retelling the story). The analysis process is pictured in Figure 2 and an example of the data analysis of one of the participant couples can be found in Appendix 4.

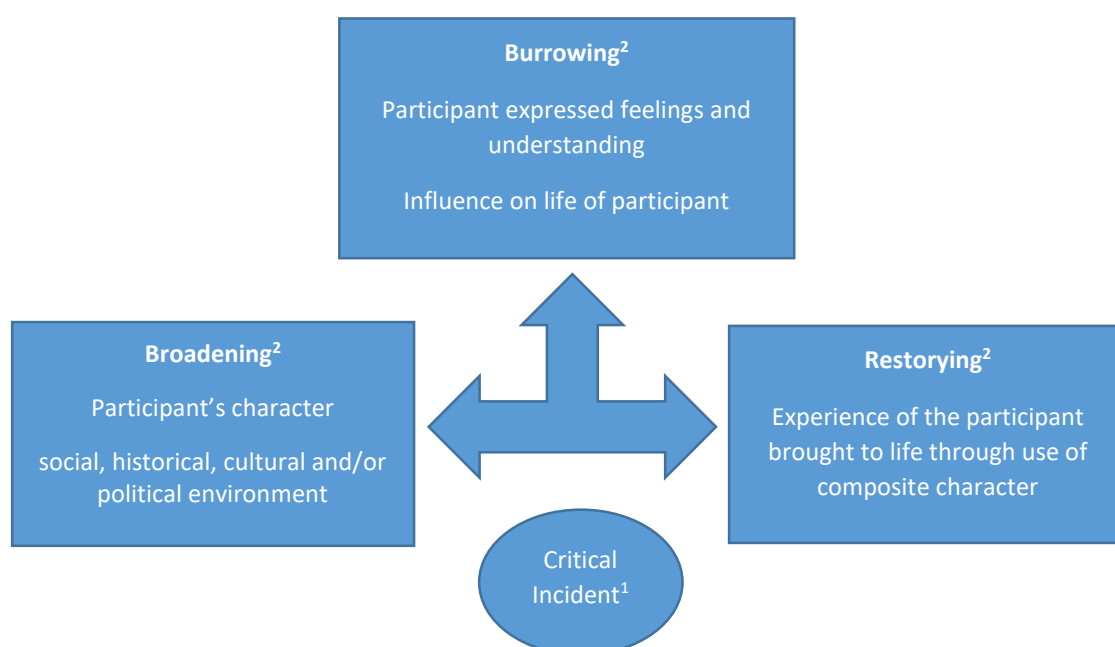


Figure 2: Picture representation of the merged data analysis tools of Webster and Mertova¹ (2007) and Connelly and Clandinin² (1990)

Data analysis was conducted only on the narrative accounts in the second interview and not on the third interview. The reason being that the third interview served as a member-checking exercise that allowed me to discuss with the participants the themes that I had extrapolated from their narrative and to ensure that I had interpreted their story in the way that they had meant for it

to be heard. The quotations utilised in the thesis can be found in Appendix 3, whereby they have been ascribed to a theme and the participant (anonymity protected by use of a code number) that provided the narrative.

3.8.1 Creation of a composite character couple

Having obtained and analysed the interview data, I constructed the composite character. Alongside forming an additional layer of data analysis, it also provided an extra level of protection for anonymising participants and their children and any other third parties mentioned during the interviews. The extra level of protection is only in relation to using the composite character or discussion of the thesis outside of the written thesis document (for example in publications or conference presentations), as the quotes being applied to all the participants in the appendix removes that enhanced protection. Adoptive parents may not ordinarily share details of their child's life experiences so that they can maintain privacy and dignity for their family, therefore I felt a deep sense of responsibility in ensuring that there was an enhanced level of protection for anonymising the identities of the participants and their children, but I also did not want to lose the voices of the participants. The decision to create a composite character couple ensured both concerns were addressed. My story is also entwined through the composite character, thereby allowing privacy for my family. The demographics of the composite couple therefore are a merging of the demographic characteristics of the participants. Re-storying transcripts through the use of fictional (or composite) characters aided me, the researcher, to distance myself from the intense involvement or similarity of incidence with a particular experience discussed by the participants, to a more removed perspective. Therefore it allowed me to look at my own experience

more objectively and that allowed me to 'see' the experience rather than be 'involved' in it (Hoogland and Wiebe, 2010; Wiebe, 2014).

The creation of a composite character couple is also a layer of analysis as the participants' stories were 're-storyed' through the composite character. The characters were utilised to show their interaction within healthcare and this aided in the creation of new knowledge as the characters detailed critical incidents and then thematic analysis was applied to the 'like' and 'other' events in addition to the critical events (further discussion in 3.4.1). Therefore the composite couple is able to illustrate common elements of the participants' stories, but also acknowledges unique circumstances which have been encountered, which allows the telling of a merged, but also a wider, story of a lesbian couple who accessed healthcare for their adopted children. The composite character creation enables this study to be more accessible as it is acknowledged that readers can find the inclusion of fictional characters compelling reading and brings the story to life (Wiebe, 2014). This could then be utilised as an educational tool to encourage debate within British healthcare, have implications for practice and also identify other areas for further research. This will be returned to in the recommendations section.

3.8.2 Characteristics of the sample

All of the participants identified as cis-gendered women and were aged in their late twenties to late thirties. One participant identified as dual heritage (White Caucasian and Black Caribbean) and the remainder (5) were White Caucasian. One participant was an American Citizen and the remainder (5) were British Citizens. All the participants were in a same-sex marriage except for one who was intending on having a civil partnership in the near future. They were all

employed and in a variety of professional roles which included administration, management, healthcare and academia. They all had adopted children of mixed genders. The shortest period of time since the Adoption Order being granted was two years and the longest period of time was five years. One participant also had a biological child.

Participant number	Age range (years)	Ethnicity	Citizenship	Marital status	Number of adopted children in family	Length of time children had been adopted at point of 1st interview
1	30-39	White Caucasian	British	Married (to P2)	2	5 years 2 years
2	30-39	White Caucasian	British	Married (to P1)	2	5 years 2 years
3	20-29	Dual heritage White Caucasian / African Caribbean	British	Married (to P4)	1	2 years
4	20-39	White Caucasian	British	Married (to P3)	1	2 years
5	30-39	White Caucasian	American	Married (non-participating spouse)	1	2 years
6	30-39	White Caucasian	British	Long term relationship (non-participating partner)	2	4.5 years

Table 8: Characteristics of study participants

3.8.3 Application of reflexivity as an insider researcher

The first chapter of this thesis introduced the concept of reflexivity as this study utilised the method of Narrative Inquiry and insider, 'in-dweller' research with reflexivity. Reflexivity seeks to explain, elaborate and deliberate the theoretical contextualisation that is applied to research (Engward and Davis, 2015). My

own reflexive self-narrative story formed part of the data collection and analysis and thus was incorporated into the composite character couple story. In addition, the process of writing up the findings was also reflexive as it allowed an exploration the participants and my own lived experience and interconnected it with wider social, cultural and political meanings (Chang, 2009). With this in mind it was important that I recognised the significance of what I, as the researcher and due to my personal characteristics, understood of the critical incidents that occurred (D'Cruz, Gillingham and Melendez, 2007). This meant that I had to acknowledge my professional role and therefore the dualism that existed of being both a lesbian adoptive parent and a registered nurse. Viewing the study findings with duality and through the lens of feminism allowed me to consider my own and my professional colleagues' assumptions and biases and how they may positively and/or negatively affect people accessing healthcare. A vital consideration of insider research is the possibility of unconscious bias being exhibited by the researcher. There are two ways of dealing with unconscious bias according to Blythe, Wilkes, Jackson and Halcomb, (2013), firstly for the research to be conducted with absolute objectivity; this was not possible due to the research not being framed within the positivist paradigm. Therefore the other and most appropriate approach was to use reflexivity. In doing this I carefully and explicitly considered myself with regards to my own assumptions and social position as research findings do not emerge directly from data collection and analysis, but are shaped by the choices that researchers make (Davis, 2020). In the first interview on both the pilot and main study, I made my personal, professional and participant position explicit to the participants and was aware of my biases as an 'insider' when designing, collecting the data and interpreting the findings of my research, however I did

not tell the participants anything about my story until the third interview (see 3.5.1). It is acknowledged by Blythe *et al.*, (2013) that in research there may be an unconscious bias due to being the same gender, sexual orientation or through building up a good rapport, but these similarities can also be seen as a positive way to engage participants as they feel 'accepted' and 'part of a collective' and relaxed so they feel able to tell their personal story. I made certain not to give my opinion of the stories that the participants were telling me, this included self-censoring my facial expressions, body language and tone, so as to avoid moderator bias. The three stage process of the interview and forming of the composite character also aided reflexivity by building more time into the data collection and analysis process. In order to bracket my experiences as a lesbian adoptive parent accessing healthcare for my children, a feminist and a registered nurse and to ensure that my experiences did not unduly influence the construction of the composite couple, I used two forms of data analysis (see 3.8) and thus an unofficial tripartite relationship began between myself, the participants and the data as I used my personal lens with multiple intersectionalities to be consumed by the transcripts; this led to co-construction of the narratives as opposed to them being solely interpretive (Davis, 2020). In addition I also kept a reflexive diary and also wrote a reflective account which has to be linked to the professional standards for revalidation with my professional regulator (NMC, 2015), this allowed reflexivity and thus reflection to have structure and purpose from a professional practice view point. An excerpt from the diary and the reflection can be seen in Appendix 8. Initially I found it difficult to identify the discrimination of the NHS is because of the limits of reflexivity, however by applying the lens of feminism I began to separate my roles of being a lesbian adoptive parent and a registered nurse and therefore

over time and through the use of reflexivity I was able to distinguish the microaggressive language and therefore discrimination that existed in the critical incidents of the participants and indeed my own story. Overall the aim of reflexivity is to allow the research process to be transparent and rigorous (Palaganas, Sanchez and Molintas, 2017) and by applying feminist theory and positioning myself under the umbrella of Narrative Inquiry, I have placed myself into a reflexive framework due to its entwinement with social constructionism (Bruner, 2004; Cresswell, 2007; Scotland, 2012).

3.9 Ethical Issues

Ethics is one of the primary concerns of all research (Ellis, 2007). Whilst there was no direct involvement with individuals such as children, young people and their families, ethical approval as a category A project was sought and granted from the University of Wolverhampton, Faculty of Education, Health and Wellbeing Ethics Committee (Appendix 2). Category A projects usually involve the participation of people, rather than secondary data sources, but are not deemed hazardous to the physical or psychological wellbeing of the participant or the investigator. More specifically:

- The research procedure is not likely to be stressful or distressing.
- The research materials are not of a sensitive, discriminatory or otherwise inappropriate nature.
- The participants are not members of a vulnerable group, such as those with a recognised clinical or psychological or similar conditions.
- The research design is sufficiently well-grounded so that the participant's time is not wasted.

The following discussion sets out the ethical considerations of the research project.

3.9.1 Informed consent and right to withdraw

All participants were sent a secure electronic mail containing the consent form and information sheet which set out the aims of the study and the participants' role in the data collection and also stated that the findings would be disseminated via a thesis and publication. It also detailed their right to withdraw from the study at any point up until the data processing stage. The participants were asked to give informed consent by signing and returning the consent form via secure electronic mail. Written consent was gained in all cases prior to the first interview date and the participants signing the consent form also indicated that they had read and understood all of the information provided to them. I also made it clear to my wife, prior to her providing consent to participate in the study, that she could withdraw at any point up until data analysis was being undertaken, in this instance only my perspective of accessing health for our adopted children would have been utilised. I acknowledged the potential for coercive behaviour towards my wife, therefore she was provided with the same participant information sheet as any other person and left to make her own decision.

3.9.2 Data protection and maintaining anonymity

It was imperative to take all practicable steps to protect the identities of the participants and their children and any other people discussed during the interviews by removing all identifying features. However I also acknowledge that when undertaking certain types of research where participants share their

specific personal experiences or stories, it may be difficult to fully protect the participant's identity even if their name and other identifiable characteristics are changed. I made the participants aware of this limitation. The third interview was completed as a way of double checking the participants were satisfied with how the data they provided was being used and that they were happy with the level of disclosure of health details that they had provided concerning their child/ren. It also offered them an additional opportunity to redact any detail they were not happy with sharing. To further maintain the anonymity of the participants I created a composite character couple (see 3.8.1). It was necessary to ensure that confidentiality and data protection (GDPR, 2018) was also adhered to and care taken in protecting data obtained through the interviews - including digital voice recorders and any transcribed information such as paper and digital documents. Holloway and Wheeler (2010) highlight that only the researcher should be able to match the real names and identities and participants should be referred to as numbers or pseudonyms, therefore pseudonyms and numbers were ascribed to the participants within the study and any third parties they discussed, including their children. The interviews recordings, electronic copies of data and consent forms were protected on a double password protected computer and any transcripts were stored in a locked cupboard in my office and will be securely destroyed via confidential waste after two years (following academic institution policy).

3.9.3 Protection from harm and safeguarding

To ensure my own protection from harm, as the researcher, I set up a separate Skype account and utilised my work telephone number for the purpose of the research project and did not share any personal contact details with

participants. The risk of harm was also reduced by conducting the interviews via Skype or telephone rather than visiting in person.

I acknowledged that if the participants spoke about upsetting situations involving themselves and their children then I would signpost them on to appropriate support services. I made certain that the participants were informed that anything they said during the interviews would be treated confidentially, unless something was raised which indicated that either they or someone else was at risk of harm. I made them aware that if this occurred then safeguarding concerns would have to be discussed with the research supervisors which may lead to a referral being made to another agency. In addition I made it clear that if any of the participants disclosed unlawful practice by a clinician or organisation then I would highlight this to them and it would be their decision if they wished to report the behaviour.

3.10 Summary

This chapter has presented the research design of the study, which has included an in-depth discussion surrounding the Narrative Inquiry approach. Feminist and Queer philosophy has been explored and aligned theoretically to the research aims. The innovative utilisation of Skype as a data collection tool, the three stage interview process, merged data analysis frameworks and the construction of a composite character couple as part of the data analysis and presentation has been explained. Finally recruitment and ethical considerations have been addressed.

This chapter has provided the platform for the following chapter (chapter 4), which will present the research findings.

Chapter 4: Findings and discussion

4.1 Introduction

This chapter aims to present the findings from the research project and begins by presenting the composite couple and their family which enables them to be 'brought to life' for the reader. This chapter presents the themes and subthemes that emerged from the participant data and has 're-storyed' the critical incidents and ascribed them to composite characters to maintain anonymity. The accounts, entwined with discussion, of the composite couple when accessing healthcare for their adopted children, were analysed by merging the data analysis tools of Clandinin and Connelly (1990) and Webster and Mertova (2007) whilst adhering to the Narrative Inquiry approach of storytelling, as detailed in 3.8. Quotes have been utilised to provide exemplars of the experiences encountered by lesbian parents when accessing healthcare for their adopted children. Therefore, the chapter has participant quotes and a discussion of the data in relation to the existing literature so that the key findings of the study can be understood in the context of the literature through the application of feminist theory.

4.2 Determination of themes

Using the combined analysis tools of Connelly and Clandinin (1990) and Webster and Mertova (2007), provided a framework with which to analyse the participant narratives (see 3.8). Each of the participants spoke about their experiences and included both positive and negative critical incidents. The themes, which also contained further subthemes, generated during data analysis were:

- Navigating heteronormativity
- Navigating healthcare settings and professionals and having an 'adopted' status

- Intersectional identity of lesbian parented adoptive families accessing healthcare
- Reflective imagery of lesbian parents and adoptive families
- Professional expectations

Table 9 illustrates the overall findings across the participants and can be used in conjunction with Appendix 3, which details the individual participant quotations.

Determined Themes	Navigating heteronormativity	Navigating healthcare settings and professionals and having an 'adopted' status	Intersectional identity of lesbian parented adoptive families accessing healthcare	Reflective imagery of lesbian parents and adoptive families	Professional expectations
Participants with number of quoted experiences in each theme in brackets.	P1&2 (2) P3&4 (5) P5 (4) P6 (5)	P1&2 (5) P3&4 (5) P5 (4) P6 (5)	P1&2 (1) P3&4 (4) P5 (2) P6 (3)	P1&2 (1) P3&4 (2) P5 (1) P6 (2)	P1&2 (3) P3&4 (1) P5 (2) P6 (3)

Table 9: Overall determined theme findings across the participants

The remaining sections within this chapter, following a discussion surrounding the composite character couple, present the analysis of the participant stories, through the 're-storying' of the narratives through the composite characters.

4.3 Composite couple

A composite character couple was designed as a vehicle to tell the story of the participants. The names utilised in the creation of the composite characters are fictitious and cannot be ascribed to any known individual. Their individual characteristics have been determined by the reflection of the demographical

data of the study participants. The reason for the inclusion of the composite character couple was to allow anonymity for the participants whilst also 'bringing to life' their stories. Therefore the composite couple will 'become', metaphysically, the participants, and will navigate through the experiences that they encountered during healthcare consultations.

Whilst the composite character is innovative and allowed for anonymity of the participants, it did also have limitations. As all of the characteristics of the participants involved in the study were included in the composite character couple, some of the characteristics (for example relationship status, professional role and age of children) may have been 'dampened down' to allow all participants to be included, therefore this may have hidden some further data heterogeneity. However alterations of data heterogeneity would only have been explicitly apparent if a differing method had been used, such as a case study approach (Crowe, Cresswell, Robertson, Huby, Avery and Sheikh, 2011).

However, some participants requested that their child's health condition and age was not named specifically as they believed this may have made them identifiable. Therefore it is not possible in the findings section (see 4.4 onwards) to have any analysis on the data that explores the intersections of the treatment of children in health care and the time spent with the child and/or parent in the consultation. The composite character couple, as with many fictional characters, has a persuasive power of narrative, therefore it holds an ethical consideration in relation to the philosophical understanding of truth and replication (or restorying) of stories regarding the consequences of taking the perspectives of others (Nunning, 2015). With this in mind it is important that the reader acknowledges that whilst the composite character couple is a fictional couple, the quotations ascribed to the composite couple are 'real experience'

quotes from the participants of this study. That said, the composite character, due to its innovation is an original contribution of knowledge from the thesis due to it being an enabling vehicle for storytelling.

Sarah and Harriet are aged in their 30s and are a lesbian married couple.

Sarah is of dual heritage (White Caucasian and Black Caribbean) and Harriet is White Caucasian. They are both working professionals, Sarah has a degree level education and Harriet has a PhD. Sarah works in administration and Harriet works within the healthcare sector. They live in a mortgaged house in Ilkley, a leafy middle-class suburb on the outskirts of the city of Leeds, England. They have two adopted children, Courtney and Michael, who are non-biological siblings. Courtney is seven years old and is dual heritage (White Caucasian and Black Caribbean), she was also born with cardiac abnormalities which have required surgery. Michael is three years old, is White Caucasian and has Foetal Alcohol Spectrum Disorder (FASD). The family have accessed primary healthcare (General Practitioner, Health Visitor service), secondary healthcare (local Emergency Department) and tertiary healthcare (specialist, for example, a Children's Hospital) with regards to Courtney's and Michael's health needs.

4.4 Navigating heteronormativity

The society in which we live has a normative of heterosexism, as detailed in the discussion of queer theory (see 3.3.3), which means that lesbians have to 'out' themselves every day when talking about their spouse or partner; because heteronormative assumptions are an everyday occurrence for people who identify as lesbians. Navigating heteronormativity is the theme that features most significantly in many previous studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton 2001; McNair *et al.*, 2008; Rawsthorne, 2009;

Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) and is the main discourse within this study. LGBT people are acknowledged as being invisible users of healthcare due to service provision being 'sexuality blind' and thereby treating LGBT people as if they are heterosexual (Fish, 2009). Thereby services and/or professionals are denying them a key part of their identity as human beings. Heterosexism, demonstrated by queer theory (see 3.3.3) has long been deemed as unintentional and unthinking by society, institutions and long standing advocates of LGBT people, thus allowing for a societal absolution from the responsibility of tackling it (Fish, 2006).

Whilst Sarah and Harriet 'normalise' being same-sex parents to Courtney and Michael within their family, their experiences in healthcare have cast a shadow over their 'normal' family existence as their family constellation challenges the term 'family' and gender roles (Burr, 2003) in a heteronormative society as it does not consist of a mother and father (see 2.7.3, 3.3.2 and 3.3.3).

'It is only when we are together [in healthcare appointments] we have been asked that question [what is our relationship?], it's never when we've taken [the children] on our own' Sarah

Harriet was in agreement with Sarah, adding that due to the societal normative being heterosexist, she did not feel that as a family they were recognised as such and they were deflated as they had to explain their family construct as it was not always understood due to the influence of patriarchy in English healthcare and gender stereotyping (Burr, 2003).

'I would say the majority of the time that we go together, people hardly ever read us as a family...usually they ask who's the mum and then we say we both are, or they just talk at one of us and then we say, "Oh, we're both their mums" or sometimes if we know it's going to be a short thing, like seeing a triage nurse, we just don't even bother explaining.' Harriet

Sarah also drew comparisons, as a result of gender role expectations (Butler, 1990; Burr, 2003), to her own childhood of being raised in a single parent family. She noted how the questions that she and Harriet are asked are far more invasive and relate to being a lesbian parent, yet she has come to expect it as the 'norm'.

'I mean we're treated differently in the way that we're being questioned. My mum used to take me to the doctor...she's a single mum...there are things that she wouldn't have been asked about...for example like family history, how we were conceived and that. I think we do get asked them because we're gay.' Sarah

The needs and challenges of lesbian parented families may be different to those of heterosexual families (Mellish *et al.*, 2013; Golombok *et al.*, 2014; Appelgren-Engstrom, Borneskog and Almqvist, 2019). This is prevalent in this study and it is noted that Sarah and Harriet experienced both positive and negative interactions with healthcare professionals. Overall Sarah and Harriet have found it most beneficial to use a strategy such as self-disclosure as lesbians (see 4.4.2.1) as this has given certainty to their family constellation in

front of the children. Previous studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) detailed that participants felt that discrimination was evident within healthcare services, and therefore they were fearful of disclosure of sexual orientation and the potential for a lack of non-discriminatory staff and staff knowledgeable about the differing needs of LGBT parented families. Sarah and Harriet both commented that whilst outward discrimination, such as use of derogatory terminology, was not frequently evident, micro-aggressive behaviour (see 3.3.3) such as asking ‘who plays Dad?’ and a lack of knowledgeable health care staff remained, potentially due to a lack of training specifically aimed at the needs of lesbian parents. This decrease in outward discrimination could be as a result of recent changes in social policy (Adoption and Children Act, 2002; Civil Partnership Act, 2004; Equality Act, 2010; Marriage (Same-Sex Couples) Act, 2013) and increasing social acceptance (Fish, 2006; Chapman, Watkins, Zappai, Nicol and Shields, 2012b; Chapman, Watkins, Zappia, Combs and Shields, 2012c; Hill, 2012). However this study highlights, through the application of feminist theory providing a lens with which to view gender role (see 3.3.2) and the effects of intersectionality and microaggressions (see 3.3.3), that despite legal changes, there remains discrimination within healthcare services in regards to a person with a protected characteristic under the Equality Act (2010) in England.

4.4.1 Family constellation and heteronormativity

The perception of what constitutes a viable structure of a family, or ‘family constellation’ is often based upon heteronormative assumptions (see 2.7.3, 3.3.2 and 3.3.3). As a couple, Sarah and Harriet found they often had to manage heteronormative healthcare experiences and expectations (of staff) which frequently related to the utilisation and understanding of the term ‘family’

and shared parenting roles. They believed that healthcare professionals needed a quick 'family framework' in order to understand their family construction, therefore considering feminist theory and binary coding of nomenclature such as 'mum' and 'dad' were roles which they perceived the health care professionals wanted to ascribe to them in order to 'make sense' of them within a heteronormative societal context (Butler, 1990; Burr, 2003). Within same-sex adoptive families, anecdotally, there are many conversations held by parents when deciding what title (such as, including, but not limited to, Mummy, Mammy, Mama) they should bestow upon themselves in their interaction with their children and to people outside of their family, such as teachers. However, it appears that some healthcare professionals are uncertain as to whether it is acceptable to ask the parents how they wish to be referred to. Studies by Malmquist (2015) and Appelgren-Engstrom, Borneskog and Almqvist (2019) highlighted how mothers in same-sex families aimed for a high level of equality within their parenting, but when meeting other people, including health professionals, they had to defend their family structure in the face of 'norms' and perceived gender roles (Burr, 2003). This finding was also echoed by the composite couple in this study.

'This is one thing we struggle with in all professional settings...is people expect one of us to be 'the parent'... to have a more traditional...well I guess you could call it a more traditional family with 'who plays mum and who plays dad'...and we really parent very equally.' Harriet

'I'm making a joke out of it now because I was trying to fit into this role and not that I was in a dad role, but if you're looking to put me in a box that

was kind of what I did, and I think that is what they [health care professionals] try and do...like they have a framework, to hang you on.'

Sarah

Sarah and Harriet were keen to add that whilst they had not witnessed the healthcare consultations of heterosexual couples, they had spoken to their families about their experiences. They placed it into context when visiting a biological sibling of Michael's (who is in a separate adoptive family).

'You do get treated differently and I think if a straight couple had gone to the hospital... it would just be like "yes there's Mum and Dad". When we go and see [child's name] (Michael's biological brother) his ten year old sister doesn't know that she's adopted because they haven't told her yet and her parents are a man and a woman... and I think it just goes to show that she doesn't know because she hasn't had to know... They don't even get that question [who is the parent?] do they... where as we do.' Sarah

This comment exposes the existence of institutional heterosexism, but also how proud and advocating Harriet and Sarah are as parents. They are clearly aggrieved that as a family they are denied their right to privacy due to them being lesbian parents, therefore it could be construed that in some of their specific dealings with state healthcare providers they are being subjected to a breach of Article 8 of the European Convention on Human Rights which details that they have a right to respect for their private and family life (Human Rights Act, 1998).

Assumptions, made by healthcare professionals, associated with family constellation in a heteronormative society are linked to patriarchy and structural practices (Sharma, 2019) and can seem overwhelming to lesbian parents and overarch their healthcare experience (see 2.7.1)

'...in an ideal world, people would just automatically read two women with a child or children as both their mums but we're [as a society] nowhere near that point yet.' Harriet

Harriet continued to say that she felt that healthcare professionals should *'pre-empt the fact the people [healthcare professionals] are not gonna [sic] get it'* and should therefore advocate for the family and inform others who are caring for the children that they have two mums. It should be noted that some healthcare professionals are sensitive and non-discriminatory and they may be seen as an LGBT ally (see 2.7.1); these professionals should be encouraged to provide support and education regarding same-sex families within their areas of employment.

Sarah commented that their local primary care provider were particularly good at acknowledging that Courtney and Michael had same-sex parents.

'The GP [General Practitioner surgery] are really good. I think it's on her [Courtney's] file now that she's got two Mum's, so they don't ask any more.'

Sarah

Harriet spoke about a time when Courtney had to have a blood test. Courtney was nervous as it can be a painful procedure and sometimes it can take longer than planned, due to, but not limited to, the position of veins or the temperature of the skin.

‘So then when she finally found a vein, Courtney had done really well, this nurse said, “Oh, well done, you can tell Daddy all about it when you get home.” ...Courtney sort of gave them a bit of a look and so I said, “Well, actually, she doesn't have a dad, she's got two mums.” Then in that way where, I don't know why I always do this, I sort of always over explain. And you could tell this woman felt really embarrassed, but also didn't say much either.’ Harriet

Outside of the appointment, Harriet then tried to ‘makeup’ for the healthcare professional’s misdemeanour and acknowledged that Courtney may be feeling uncertain or confused as to why the nurse presumed that she had a father, which further links to the complexity and expectations of a patriarchal society (Sharma, 2019). This could be showcasing Harriet’s strategic protective instinct over her child and as a way of being ‘proud’ of the family identity (see 2.7.2 and 2.8) whilst challenging the need for acquisition of a perceived gender role (see 3.3.2).

‘I said, “she doesn't know that you've got two mums and lots of us do have two mums like [friends names], and that felt a bit weird didn't it that she said that.” I tried to acknowledge it. But I do feel annoyed by it because

these little moments chip away at their sense of self and security in having two mums.' Harriet

Courtney hearing a healthcare professional make an assumption that she has a father, is an example of a micro-aggression and could be a damaging experience as it may make her question that her family is 'incorrect' as it is not 'traditional' or the 'norm' in the opinion of the nurse (see 3.3.3). This is also important as a Registered Nurse is an advocate, role model and has a code of conduct (NMC, 2015) to adhere to with regards to professionalism and professional expectations (discussed further in 4.8). Perrin and Kulkin (1996) commented that in their study, respondents felt that their family constellation had many strengths and that paediatricians should be aware that the children are not deprived, they are wanted children and that the role of the family unit is similar to that of a nuclear family (Perrin and Kulkin, 1996). This study's findings agree with the argument by Perrin and Kulkin (1996) and through application of feminist theory (see 3.3.2 and 3.3.3) demonstrates the need to challenge the stereotyped gender roles within an English perceived societal norm family construct of a mother and father, which still exists within the English healthcare system.

4.4.2 Strategies to navigate accessing heteronormative healthcare

Lesbian parents use a significant number of strategies either consciously or subconsciously to navigate their way through the challenges that they face when accessing healthcare for their children in a heteronormative world as the relationships that they make with people and others (for example, healthcare institutions) will enrich or curb the choices that they make (Simons, 1995). The strategies employed by the parents in this study were used in order to protect

the children and their familial identity and consisted of self-disclosure of sexuality, and the use of power to navigate healthcare consultations.

4.4.2.1 Self-disclosure of sexuality to protect individuals

Disclosure of sexuality is an overt strategy and how lesbians manage their level of disclosure or 'outing' during their interactions in healthcare settings will vary for each individual parent and is often shaped by their previous life experiences (Chapman *et al.*, 2012a). Self-disclosure of sexuality by the parents to protect individuals, includes their children, but on occasions includes healthcare professionals. McNair *et al.*, (2008) discussed disclosure of sexuality by confirming that the main aim of the parents adopting this strategy was to protect their children. Harriet commented that she self-discloses her sexuality rapidly during health consultations with the children.

'I out myself fairly quickly. So that's just a natural tendency that I do.'

Harriet

As discussed in Chapter 2, Perrin and Kulkin's (1996) study, conducted 24 years ago in the USA, it is clear that regardless of the year of the study and the location of the families, self-disclosure remains a necessity for many lesbian parents. Harriet qualifies one of the reasons for this when she discusses the importance of Courtney and Michael 'seeing' that they are a normal family. However, being faced with people's questions and reactions could make their family seem 'unnatural' to the children. The micro-aggressions associated with the normative of heterosexism and public outing are an expected occurrence for adopted children with sexual minority parents due to the increase of LGBT parents adopting and the continuing controversy surrounding it (Farr *et al.*, 2015).

‘...before we had the children it had been a long time since I had had to walk into a room and announce my sexuality. But since we’ve had the children, we walk in together and people go...”and you are?”...“we’re both mum, we’re together and this is our son”...and not that I have a problem with it, because I think it’s actually important that the children see that this is the norm. This is normal for us.’ Harriet

As noted in Chapter 2, the study by Mikhailovich, Martin and Lawton (2001) reported that factors which had been identified by parents as pivotal to their self-disclosure, were believing that it was relevant to the care of the child and also a political statement and commitment to being ‘out’ as a lesbian. Whilst these two factors were not acknowledged by Harriet or Sarah, the parents confirmed that being open and honest with Courtney and Michael was important, which in accordance with the findings of Mikhailovich, Martin and Lawton (2001) and Goldberg *et al.*, (2019) could provide a positive rapport with the healthcare provider. Sarah revealed that she self-disclosed as a way of protecting the children, which is endorsed by Malmquist (2015), and also the healthcare professionals as lesbian parents often feel obliged to ‘come out’ and defend their identity as a way of protecting their children and their identity. It is also acknowledged by Fish (2006) that patients who ‘come out’ are likely to be more satisfied with the care they receive as they experience greater ease in communicating with health professionals including involvement of their partner in treatment decisions. Therefore this approach could also be taken by lesbian parents to empower parents accessing healthcare for their children and protection of their children by presenting an open and honest front and by

challenging institutional patriarchy by presenting as two women with no subordination due to gender (Butler, 1990).

Protecting healthcare professionals through self-disclosure of sexuality was an unexpected thematic finding of this study. This strategy was implemented by Harriet and Sarah, as when they had not done this previously, it led to assumptions being made about their family constellation.

'I think it's a consciousness [self-disclosure of sexuality] that I've developed over time and because I think it is important to protect whoever you're interacting with... in this case the medical professional...so to protect them from feeling awkward and saying the wrong things. I suppose in that way it also protects them in front of [the children].' Sarah

Protection, as highlighted by McNair *et al.*, (2008) could be through 'proud' disclosure whereby a united front was portrayed and a need to disclose and therefore reducing the confusion of the healthcare provider with regards to family constellation, or it could be through non-disclosure and therefore being 'silent' and intentionally excluding a parent.

4.4.2.2 Using power as a protective strategy

Exulting a position of power as a result of a professional position or socioeconomic status was highlighted as a strategy to successfully navigate healthcare consultations and has an association to feminism due to the contested nature of vulnerability and power relationships (Stemple and Meyer, 2014). Having a 'link' to a profession through your own professional role was deemed by Sarah to be important in ensuring they received a positive

experience in healthcare. She commented that when entering a healthcare setting, especially for an emergency appointment, when the healthcare professional may not be known to them, that she sometimes wore her work identification badge as it has a National Health Service Trust named on it. She does this as she believes that she will have an improved outcome for the children as she has a professional identity linked to healthcare; this is supported by Svantesson, Carlsson, Prenkert and Anderzén-Carlsson (2016) who identified that healthcare professional patients receive a higher commitment to secure and prioritised care from other healthcare professionals.

'It is the emergency ones [appointments] that aren't good...I still feel a little bit on edge... but because I work there now... I think it would be better... I'd wear my badge.' Sarah

In addition, Harriet made a point of noting that she believed that she was not always treated differently, in a negative way, and apportioned this as potentially being due to her professional positioning, socioeconomic background and the area in which they lived which could be linked to a lack of gendered and positional vulnerability (Stemple and Meyer, 2014). This mirrors the findings of the study by Perrin and Kulkin (1996) which highlighted that the lesbian parents with a high level of education had the highest level of self-disclosure. It is also noted that societal perceptions of affluence have led to assumptions that LGB people comprise an elite socioeconomic group and as such are insulated from discrimination (Fish, 2009).

'I think I'm treated differently because I'm articulate and because I'm white and educated... it's also partially the medical professionals you end up seeing [in Ilkley]...will probably come from a higher socioeconomic background. So if they identify you in some way as 'like them' then I think you are often treated better. I feel like I've been treated with respect because of those different markers. And in some ways... [Ilkley] is a very liberal place so having self-identified myself as a lesbian and well-educated then I'm guessing...because my title is doctor [academic PhD]...if anything, that aligns with the people they want to be with. So I think if we were a same-sex couple from a different background we may well be treated very differently or if we're living in a different location.'

Harriet

These comments made by Harriet are not new as it is acknowledged that people with higher education levels can be more assertive and therefore may find social and healthcare situations easier to navigate (Shields *et al.*, 2012). The first study that discussed social demographics as a reason for a high level of self-disclosure of sexuality was in 1996. However this study highlights that power as a result of professional, educational and socioeconomic background is a reason that allows the successful navigation of heteronormativity within healthcare by some lesbian parents.

4.4.3 Summary

In summary, navigating heteronormativity during healthcare consultations has long been a challenge for lesbian parents and it has been commented on in historical literature that positive and negative attitudes are encountered whilst navigating the healthcare system. There is no British literature yet published

that disproves the historical experiences, and the participants in this study share similar experiences to their international counterparts. It is important to note that the participants of this study did not use the terms 'discrimination' or 'homophobia', however from the narratives it is evident that institutional homophobia is present and discrimination or 'being treated differently' remains apparent in English healthcare settings. This study has highlighted how the lesbian parents have encountered minority stress (Meyer, 2003) (see 3.3.3). It has also showcased how they have navigated heteronormativity and assumptions made about their family constellation in health services in England and has detailed some of the strategies, which are overt and display confidence and are therefore proactive strategies, that they have employed such as self-disclosure of sexuality and use of power to balance the relationship between themselves and the healthcare professional. It should be noted that other types of strategies were employed by the participants which were more negative or passive and these are discussed in 4.6.1.

4.5 Navigating healthcare settings and professionals and having an 'adopted' status

Adopted children are more likely than biological children to have additional health care needs, learning disabilities, developmental delay or mental health challenges (Bramlett, Radcliff and Blumberg, 2007). They are also more likely than biological children to have attended a preventive medical appointment and/or dental visits during the previous year, to access healthcare provision and to access mental health support if needed (Bramlett, Radcliff and Blumberg, 2007). When considering and working with adoptive families and indeed, adoptees themselves, it is important to develop an understanding of the adoption process (see 2.3.1) in general within England and also an awareness

of the specific child's reason for adoption (Golombok, 2015). Adopted children, as they get older, may begin to develop a desire to know more information about their biological family and to understand the reasons surrounding their adoption (McClean, 2016). When children are adopted by same-sex parents, they often face the challenge of being questioned over who their parents are due to them being the same gender (Mellish *et al.*, 2013). Mellish *et al.*, (2013) determined that nearly all adoptive parents in their study had spoken to the children about their adoption and had used age appropriate language as a form of protection to explain the reasons for their adoption. Therefore, it is vital that when adopted children are accessing healthcare, that they are met with certainty, inclusion and sensitivity by healthcare professionals (Verrier, 2009). If they do experience negative attitudes discriminating against adoptive children/parents the child may feel that their identity is not accepted (Farr *et al.*, 2015).

Harriet and Sarah discussed a time when they had taken Courtney to a health appointment and they faced questioning similar to the discussion points above.

'We had to go to the one year health check for all looked after children and ...well considering they deal with adoption and adopted children they still don't get the terminology right... she said "what about her real mum?" and it's like really, it's not about that, we're her real mum.' Sarah

Harriet further drew upon the use of the term 'real' mum and the children's life story. She regaled how she would explain the children's life story to healthcare professionals as a way of protecting the children from any further questioning

about their adoption or parentage. It should be noted that this discriminative and undermining challenge over being a 'real' mum or it 'not being possible' to have two mums, is not unique to adoption, it could also be heard by lesbian couples whereby the child is biologically related to one of the couple (Kelsall-Knight and Sudron, 2020), as determined in the pilot study (see 3.7). This issue is more likely to be apparent for lesbian parents due to heteronormativity in healthcare settings (see 4.4) and results in the intersection of discrimination between adopted children/parents not being seen as 'real' parents and the heteronormative assumption and homophobic discrimination that a child cannot have two mothers.

'We don't want to have to explain their whole life story to everybody all the time but we do try to be quite open... but I think we probably end up doing that more than straight couples with adopted children because when they ask something like, "Who's the mum?", ...you almost feel like we have to explain ourselves more and I don't know why. We could just say, "Yeah, we're both their mums", and leave it at that, but you feel like you have to blurt it all out so that they understand. I think there have been times in other situations, not in healthcare, where people have really not understood what we meant when we have said that we were two mums and really questioned us and undermined us, and you don't want that to happen in front of the children. I think sometimes people have said things like, "Oh, that's not possible, of course you both can't be their mum, who's the real mum?" I think you want to pre-empt that in a way.' Harriet

Utilisation of the term 'real' needs to be considered due to the destabilising impact of this type of language, especially when heard by a child. Therefore for a child who has endured uncertainty in their life due to being in foster care, if their birth parent is described as 'real' then they may ascribe 'not real' or 'pretend' to their adoptive parent (Neil, 2012). Utilising words such as 'real' to describe biological parents may reflect the broader social context where blood relationships are considered to constitute real kinship (Brodzinsky, 2006; Neil, 2012). It is important to note that people will interpret the meaning of words differently according to their background, therefore the healthcare professional means biological parent when referring to 'real'. However, this terminology may further destabilise the child's sense of permanence if they believe that their adoptive parent is not 'real'. Harriet encountered a lack of adoption competence (Goldberg *et al.*, 2019) surrounding the legalities of adoption depicted by a health care professional, which highlights that some healthcare professionals wrongly consider that the biological parent has an inalienable lifelong right to be involved with the child.

'...We had to take Michael to the Children's Hospital and she was a consultant and I will always remember her because he was sat there with us and she said "you know he has this condition and I think you need to ring his real mum because she has a right to know". I remember sat there thinking "no she lost that right the minute she laid a finger on him". But, irrespective, the point is it was in front of Michael and she referred to someone else as his parent, and he knows quite clearly he has us. He's never had another parent so his understanding of the term parent...and it almost implies that she [birth mother] has some hold over him still and that she can come at any point. How he

interprets that...y'know it's little things like that that puts doubt in his mind as to...am I staying? But they [the healthcare professionals] don't really realise what damage they could be doing to his identity.' Sarah

Sarah voiced her concerns over the dismissive terminology used regarding Courtney when the family attended an Emergency Department. Sarah and Harriet were inappropriately questioned over their relationship to Courtney and their family constellation was not positively acknowledged. The language utilised was discriminative, impersonal, dehumanised and as such referred to Courtney as being an 'object' rather than a human with thoughts and feelings. This could have had a significant long term impact on Courtney's self-esteem, self-worth, belonging and identity. It could also discourage her from accessing healthcare services independently as she begins to enter adolescence and adulthood, due to having a negative experience (Coyne, Sheehan, Heery, and While, 2019).

'I guess people's understanding of adoption is then gonna [sic] have an impact on how they perceive our family. We went to the local hospital [Accident and Emergency department]...and saw a Registrar. Courtney had an injury...and we were taken through to one of the cubicles. I walked ahead first with Courtney and as we walked through, the curtain was abruptly pulled across in front of Sarah and Michael. Sarah opened the curtain and said "do you mind if we come in...we're part of the family?"...to which she [the Registrar] said in front of both children "well, who are you?"...and I said "I'm, his mum" and then she looked at Sarah and said "Well who are YOU then?"...and Sarah said "I'm also his mum"...and we

said our son hadn't been home very long so we wanted to keep them together ...and she said...in front of Courtney... she was 5 at the time...turned to her and said "what is she? Is she fostered? Are they in care?"... she [Courtney] just looked horrified...and just looked at us and.... your instinct is that you want to protect the children...and you just say "no, she's my daughter. This is her brother and this is their other mum." But it had quite a profound effect, in that every time we go to the hospital she says "I'm not going to see that woman that wasn't nice to us again?"...she's 7 now and still refers to the incident as "that horrible woman at the hospital" and doesn't want to go.' Harriet

Harriet further discussed the incident and the discriminatory manner in which they were spoken to.

'That terminology used [by the doctor]....to describe her. "what is SHE? Is she a care kid?" Y'know she's not an 'it', she's a child and when you want to know that information there are other ways in which to ask it. And I think it was just ... you feel like this second class citizen because you didn't give birth....some people think they have this automatic right to talk about you...in that manner...And talk to your children disrespectfully just because they're children. Like they don't matter. She had no idea whether she was adopted or not, we could have given birth! So [she] just talked about [us] like [we] are a piece of paper...like [we] are not here.'

Sarah

Utilising the correct terminology (such as biological rather than ‘real’ parent), which is further discussed in 4.5.1 and 4.6, and understanding the legal status of adoption in order to demonstrate being adoption competent (Goldberg *et al.*, 2019) is imperative to ensure a secure family unit with no uncertainty (Verrier, 2009). In addition it is also vital that healthcare professionals recognise differing family dynamics or constellations (Dibley, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) and be respectful and inclusive of them and refrain from microaggressive behaviour (see 3.3.3). Talking about adopted children in a dismissive way links to the societal and internalised shame associated with their early life experiences if they were taken into care due to being abused or neglected (Deblinger and Runyon, 2005), thus adopted children may feel there was something wrong with them which is why they were removed from biological parents. Therefore negative interactions can act as a trigger (see 4.5.1) to children experiencing negative emotions about themselves.

4.5.1 ‘Triggers’ associated with adoption

Adopted children may exhibit behaviour which is not understood by people who are not known to them, for example in health settings. Children who have experienced trauma may suffer from ‘triggers’ of fearful situations. The ‘trigger’ is the capacity of the memory to bring elements of an experience from one moment in time to another (Perry, 1999). In order for any experience, traumatic or not, to become part of a person’s memory, it must be ‘sensed’, in order for this to occur it must be experienced by the individual person. The prime ‘directive’ of the human brain is to promote survival and therefore, as a result, the brain is ‘over-determined’ to sense, process, store, perceive and mobilize in response to threatening information from the external and internal environments

(Goldstein, 1995 in Perry, 1999). Each area of the human body and brain are utilised to respond to a 'threat' by going into 'survival mode'. This survival mode can look like 'challenging behaviour', enhanced and softened down emotional state and dysregulation of the child (or person) who has experienced the traumatic event previously and therefore is now enduring a 'trigger' (Perry, 1999; Verrier, 2009). It is important to realise that the cognitive, emotional, social, behavioural and physiological effects of a trauma may impact an individual person for a great deal of time, sometimes for their lifetime (Perry, 1999).

Inclusion and the significance of identity are of paramount importance when lesbian parents are accessing healthcare for their adopted children. A lack of inclusion or uncertainty regarding their or their family's identity could be a trigger for an adopted child. Regardless of whether a child has been moved through differing foster placements or has only had one move from their birth family to their adoptive family, there remains an intrinsic query concerning their permanence. If details pertaining to the adoption and the presence of social workers and/or birth parents are said in the medical setting then it could enhance vulnerability for all people in the situation (see 3.3.2) and give rise to permanence concerns for the child.

'I think it's still that vulnerability. He knows he's our son and we're going to be together forever...but I wonder if there's always that element of him wondering if something is going to change....that I don't know if he'll ever fully accept....there are still little things...he'll say "oh I'm not going anywhere".'

Sarah

Harriet spoke about how Courtney would experience 'triggers' when in certain healthcare settings due to the treatment of the family by healthcare professionals and the effect that it had on their ability and her potential willingness to access healthcare. She also alluded to how the response of a healthcare professional can alter their ability to receive the required healthcare.

'She acts differently in doctors' offices... I don't know if it's because she had been with birth parents to the doctor's and so that was one of the differences in behaviour...and I think I even checked ahead of time to make sure that it was a female doctor but she refused to let the female doctor see... I think it might be a trigger [attending the doctors]...she becomes a different person in the doctor's office, like very shy or hides behind you and will be seeking attention. The difficulty is more in terms of how she reacts to that environment... you go to the GP and have a 10 minute appointment...and she's refusing to do something that's cutting into their time...so then they don't necessarily know how to respond... and some GP's are better at responding than others.' Harriet

Harriet and Sarah furthered the discussion by drawing upon the desire of some healthcare professionals to discuss birth history and the reason for adoption, when it was unrelated to the ailment that the children were presenting at the appointment with. The parents acknowledged that there were certain circumstances when healthcare professionals would need to discuss the child's biological background due to the type of illness, however this was not one of those occasions. This led to them becoming anxious and agitated as they felt

like their children's treatment has been delayed due to inappropriate (and at the time, insignificant) questions. These situations could have potentially been damaging to the child's welfare as not only were they in a health setting that could already trigger anxiety, but there were also discussions concerning the potentially traumatic background of the child in front of them.

'This lady [a nurse]...she could not get into her head which one of us was birth mum? "Which one of you is her biological mum? Which one of you is Mum? Who were her parents?" We had to explain that she's adopted, again, we constantly have to explain that she's adopted, [Courtney] was burning up and I was just saying 'forget about us, sort her out!' I was just saying 'how has her temperature got anything to do with genes?' Sarah

'I was angry about having to explain who we were, but it's become the norm for us. She [Courtney] wasn't well and we were concerned for our child, so why are you asking me about who is Mum, you know it doesn't matter, the fact that we are both there and we are both her parents... and she is unwell and it felt like that wasn't at the forefront...we've brought her in and we want to know what we can do to make her feel better, not go over who gave birth to her because that's irrelevant!' Harriet

Harriet commented on healthcare professionals questioning about the presence of social workers in their lives. This could be a 'trigger' to some children as the trauma and major life changes that children who have been in care may have experienced, and their association of that period of time potentially with social workers could increase their anxiety, distress and insecurity.

'I think because they're adopted we often get asked things like, "Do you have parental responsibility, do you have a social worker or anyone else we should call?", which I understand because initially [at the first appointment] the adoption hadn't gone through but sometimes I just feel like that gets asked too often and I think Courtney is a really bright kid... you just see her ears pricking up a little bit at them asking, whether they have to ring a social worker.' Harriet

This was further explored by Sarah and she additionally felt that healthcare professionals did not understand the adoption process (see 2.3.1) and thus lacked adoption competence (Goldberg *et al.*, 2019) and therefore some of their consultation time was spent explaining the process and legalities before being able to address the children's health needs.

'I think when we first adopted them, we were definitely asked about things a lot more..."have you got it [the Adoption Order] sorted yet?" and we'd say "this is our social worker's phone number" when we'd ended up going to A&E. I think they [the healthcare professionals] said a lot more things like, "do they still have contact with their birth parents?"... I think they couldn't totally understand the situation... but I think people don't always realize that that's how adoption works. That you are a looked after child and then placed for adoption... and you are the adoptive parents but you don't have the Adoption Order [as there is a timeframe and a court process that has to be adhered to]... I think they [the healthcare professionals] were a bit more questioning then. And they [Courtney and

Michael] were younger as well, so it felt a bit easier being questioned like that when they were younger, whereas now when they're so aware, I think it's harder.' Sarah

The parents observed that due to Michael being a different ethnicity to Sarah, they felt that healthcare professionals questioned his parentage, whilst they were trying to solidify their place as a family. Harriet further commented that misconceptions and questioning about adoption by healthcare professions can make her query her role as a parent which is supported by Butler (1990) and Burr (2003) when considering the 'role' that people play in a given situation. However these challenges could cause a trigger for the adoptive parents, which could undermine the sensitive bond building that has been developed between the parents and child.

'The main priority is [Courtney and Michael] and when we first had [them] we were proud parents...you're trying to establish that they are your child and you're getting to know that child as well, and when you're trying to feel comfortable in being mum and Mummy... when you are feeling that...you forget that they're adopted. Then when you go in (to the healthcare setting) and they say 'well, who's mum?' it takes you right back... and you don't feel like you're important. It just makes you feel...who are you really? That's why it's nice when somebody understands it and reaffirms who you are... when someone questions [the parentage] it's not nice.' Harriet

One area which was a particular challenge for Harriet and Sarah was the legal surname of Courtney and Michael being different to theirs until the point at

which the Adoption Order was made. The National Health Service has to utilise a person's legal name but a 'preferred name' can be chosen by the individual. Therefore when children are placed for adoption, depending on their age, they may or may not already be aware of their surname. Therefore it may be confusing or a 'trigger' for the child to hear, if their name is called out, or they see on paper that they have a different surname to their parents. Harriet commented on this occurring due to the age of Courtney when she was adopted.

'We said you'll use this surname, it's not the legal one but it's the one it will be changed to [when the Adoption Order is made] and it identifies her... and they were completely fine with that but then... dealing with the medical setting and constantly seeing a different GP or going to specialist appointments...it's a new person every time, they only have the [legal] name on the system, so she would hear that.' Harriet

Juxtaposed to the above examples, Harriet commented on an example of good practice, whereby a surgeon was aware of the effect that discussing 'triggering' information could have in front of the children. Unfortunately from the findings of this study, this type of inclusion and sensitivity by healthcare staff is not common practice.

'If he does want to ask something that's sensitive in terms of birth history or medical history, he gets them busy playing with something or takes one of us aside and asks us. He really considers their feelings.' Harriet

4.5.2 'Hidden history' of adopted children

When discussing the challenges of adoption, one sub-theme that became pertinent through the discussions with Harriet and Sarah, was the 'hidden history'⁸ of Courtney and Michael. I have given the term 'hidden history' to explain that whilst adoptive parents receive a child protection record and a significant amount of information regarding the social, emotional and physical health of the child prior to them entering the adoptive family, there is so much history that they are not a party to. For the simple reason that they were not there to witness key health or life events in the child's life prior to the adoption. People who are not adopted may have a 'hidden history' due to being unable to verbalise what happened, but they may also be able to rely on their biological parents or siblings to tell them their story retrospectively as they may be living/have direct contact with them. Adopted children may not have this due to having no contact or only indirect contact through letters with their birth family, therefore their story of their early years may be lost or incomplete. Each child that is placed for adoption has their own 'hidden history' as they were there (in their past) and lived it (thus the ontology of historical realism and how the child may shape their future understanding of the world will begin to be determined), but they may not be able to verbalise it. There may of course have been other people there (foster carers or birth parents) but it cannot be guaranteed that all of this information (as information which may be deemed insignificant to one person, will be significant to another) will be passed on to the adoptive parents. The history could include happy 'childhood' occasions such as when the child

⁸ 'Hidden history' – the history of a child who is looked after by the local authority, in kinship care or adopted and due to their life experiences and movement between placements, elements of their life story are not fully known. This may be due to information transfer failure, death of family members or inability to verbalise the experiences by the child.

first smiles, their first haircut, birthday parties, but could also include previous medical appointments, hospital admissions and abusive incidents. Healthcare professionals appear to ‘forget’ that adoptive parents have not been the child’s parents since birth and they therefore may be playing ‘catch up’ with regards to learning about and understanding various medical conditions, this again links into professionals’ adoption competence (Goldberg *et al.*, 2019). Or the child may have a health condition which was exacerbated or caused when they lived with their biological parents, therefore health professionals will need to be aware and sympathetic of this and not inadvertently induce shame on the parents (for example by passing judgment on tooth decay or the presence of foetal alcohol spectrum disorder).

Harriet commented that she sometimes felt judgement from health care professionals due to challenges Courtney and Michael had. These challenges could be behavioural ‘triggers’ (see 4.5.1) or could be medical and dental ailments due to inappropriate food or living circumstances which occurred prior to them being accommodated in local authority care. Courtney had tooth decay as a result of her experience with her birth family. But this became part of Courtney’s ‘hidden history’ when she was adopted and the dentist did not appear to be aware.

‘I think I’ve done the best I can [at parenting]... but it’s not really pleasant...to go to those appointments... every time we go to the dentist I get told to limit her sweets as she has got tooth decay and small cavities...and you feel like you’re getting judged every time’ Harriet

Courtney has a medical condition which she has required surgery for. However two of these surgeries were completed before she was adopted by Harriet and Sarah. Sarah commented on how healthcare professionals expected them to fully understand Courtney's condition as it was present at birth and they spoke to them without always giving them full information, as they presumed that Sarah and Harriet already knew it.

'[the surgeon said] "I must have met you when she had her previous surgery." Harriet got annoyed and said, "We tell people this all the time and I don't know why it doesn't get passed on... she didn't have her previous surgeries in this hospital and we weren't there for them, because we have adopted her." I think Harriet was probably more annoyed because this consultant had just been talking at me, but people often presume that we have been through the entire process with her and that we've had everything explained antenatally and that we've already been through the intensive care and everything with the previous surgeries, and we haven't. I think that when that kept being said, it started to annoy us, when we were feeling tired and didn't really feel very acknowledged of the journey we'd all been on. I think we always feel like we're playing catch up and because she was older when she came to us, it was hard to replicate that experience that people would obviously go through when they find out antenatally, when they have appointments where you are talking as adults where you can have a conversation without the children there. Whereas our first time we met with the [specialist] nurses, they [Courtney and Michael] were both there, very aware. We did feel like we were always

trying to piece together the knowledge a bit more than I think we would have done if we had been where we started from pre-birth.’ Sarah

The presumption by healthcare professionals of parents being ‘there’ throughout the child’s life is not an unnatural concept, however healthcare professionals, by showcasing adoption competence (see 2.7) (Goldberg *et al.*, 2019), should be aware with adopted children that their adoptive parents may not have always been there and therefore provide additional support (and time) when needed.

‘People presume that we’ve been through the whole [medical] journey with Courtney...we’re probably sometimes treated the same when we shouldn’t be and there’s not actually been the acknowledgment of that, and then sometimes we have been treated differently. For a while, when we had outpatients appointments, we would often be asked to see different members of staff again... or we would ask to have a bit more time with the consultant again. So I think when we’ve really asked, they have acknowledged that there’s a difference there, in a positive way and given us a bit more support to understand more about her condition.’ Harriet

It is imperative that healthcare professionals are aware of the ‘hidden history’ of adoptees and the implications that this may have on their parents, for example, not always having all the necessary medical information, or not being able to answer questions on hospital admission paperwork in relation to achievement of childhood developmental milestones. Therefore it is vital that ‘hidden history’ (see footnote 8) is added to the concept of adoption competence (Goldberg *et*

al., 2019) and that the English adoption process and the family constellation of being an adoptive family is acknowledged as 'normal' and intrusive questioning is limited and this will also minimise the use of perceived microaggressive language (see 3.3.3). Adoptive families are used to enduring a myriad of questions having completed numerous intrusive forms related to their personal circumstances during the adoption process, therefore they are unlikely to become too disgruntled by additional questions from healthcare professionals. However when the volume and intricacy of the judgmental and potentially damaging nature of the questions begins to encroach on their privacy and challenge their identity as a family, they understandably will want to try to protect their children. Sadly, when these questions are asked in front of the children the parents cannot necessarily divert the question or distract the child, therefore they may be unable to protect the child.

4.5.3 Information transfer of family constellation in healthcare settings

Effective communication has long been a precursor for successful navigation and management of healthcare. Sarah and Harriet highlighted the importance of transferring information (such as related to their family constellation) to those who need to know, so that there is no ambiguity and the family are met with certainty. Sarah felt that it would be useful if the local authority responsible for placing the children for adoption had communicated with all healthcare providers so that the parentage and circumstances for adoption were known, alongside important medical information and transfer of full medical records. When the medical records for Michael were transferred some details were omitted (childhood vaccinations) which led to him having incomplete health data.

'It would be good to have that on the radar now that he's adopted and has same-sex parents...what might have helped is if perhaps the local authority could have that communication with Primary Care, but maybe it would have helped [initially when children are placed] and could help in the future... like when a child's notes came through...the notes came through but all the immunisations were missing.' Sarah

Sarah and Harriet felt that in order to navigate healthcare more easily it would be beneficial if relevant details pertaining to their family constellation and medical history and behavioural challenges were held within the children's records as evasive questioning by healthcare staff led to 'triggers' for their children. They also commented that healthcare professionals sometimes assumed the type of abuse that their children had endured and therefore questioned them (the parents) during the consultation, which was inappropriate as it could have had a damaging impact on the child due to the 'trigger' and 'hidden history' (see 4.5.1 and 4.5.2).

'So whether or not they understand adoption... you get asked "has she been sexually abused?" whispered in front of her. I feel that there should be some sort of note so that they're not [asking this in front of them]. [The notes should say] this is an adopted child. Anything that is medically relevant, should be held in there. I don't know what those kind of notes look like...but they [the healthcare professionals] should not be asking that or playing catch up or trying to find out what's going on with this child who's going across the room hiding under things.' Sarah

4.5.4 Summary

In summary, encountering healthcare settings and professionals and having an 'adopted' status has highlighted the challenges for adoptive parents. This finding has highlighted that being adopted leads to discrimination within healthcare, due to a lack of understanding and sensitivity by healthcare professionals. Similarly to how lesbian parents manage the overriding heteronormativity of health care setting by outing their sexuality (see 4.4.2.1), they also 'out' the adopted status of their children to protect the children from 'triggers' and for also acknowledging their hidden history. This study has highlighted that in order for an adopted child and their parents to successfully navigate healthcare encounters, it is imperative that healthcare professionals are adoption competent (Goldberg *et al.*, 2019), understand hidden history and its implications, have an awareness of the experiences of children in care (see 4.5.2) and do not make assumptions which could lead to children experiencing 'triggers' (see 4.5.1). By acknowledging these factors the healthcare professional should thereby improve their interpersonal skills and become trauma informed (Menschner and Maul, 2016) and provide trauma informed care⁹.

4.6 Intersectional identity of lesbian parented adoptive families accessing healthcare

This section brings together strands of discussions and findings from 4.4 and 4.5 to highlight the effects of intersectionality. Intersectionality increases the likelihood of oppressive practice and micro-aggressions (see 3.3.2 and 3.3.3). As discussed in section 3.3.3, queer theory created a dialogue throughout all

⁹ A trauma-informed approach to healthcare aims to provide an environment where a person who has experienced trauma feels safe and can develop trust (The Kings Fund, 2020).

intersections including, but not limited to, sexuality and race, and it is common for a person to have multiple intersections which make up their identity (McCann and Monaghan, 2020). Whilst the focus of this study is the experiences of same-sex parents in healthcare, the intersection of race which Sarah disclosed also requires discussion. Sarah's fear that due to her ethnicity, she would not be taken seriously as a parent highlighted that she had to deal with compounding multiple oppressions. She therefore asked Harriet to take Courtney to the surgery as she felt that her concerns had been previously ignored and that the doctor would respond better to a white skinned person given the discrimination and oppression black people are known to face within the healthcare system (Salway, Mir, Turner, Ellison, Carter and Gerrish, 2016).

'I said "look I'm not taking her to the doctor again because they have a habit of sectioning black people"... so [Harriet] took her...she got an inhaler straight away.' Sarah

'I sometimes feel that people will talk to you [Harriet] more...I do think it's a colour thing. We mainly deal with White and Asian health care professionals and there's only one Black doctor that we've dealt with... and that's Dr xxxx who talks to all of us. White and Asian [health care professionals] will directly speak to [Harriet] more than they speak to me. I know it sounds really bad, but I'm used to it.' Sarah

It is unacceptable that Sarah believes that racism is a contributing factor to the level of engagement with healthcare professionals. Her comment of being 'used to it' was also unacceptable. In line with the Equality Act (2010) and the

NHS Constitution (DoH, 2015a) and various healthcare professionals' codes of conduct (GMC, 2014; HCPC, 2014; NMC, 2015) it is unlawful to discriminate against people on the basis of race.

Sarah and Harriet had varying viewpoints surrounding the intersectional play regarding the identities of parents, adopted children and healthcare professionals with regards to navigating healthcare. Sarah felt that at times the intersectional play between being dual heritage, a lesbian and an adoptive parent, was a barrier to and hampered her ability to successfully access and manage healthcare consultations due to the discriminatory cultures which exist within the NHS as an institution, and the individual attitudes and beliefs of staff. In order to protect the children from heteronormative and adoption related assumption and poor practice, Harriet and Sarah employed protection strategies to address intersectionality; these included 'outing' themselves as lesbians and 'outing' their children as adopted, however Sarah 'hid' from view in regards to her race. Therefore it can be seen that they are not applying the same strategies for dealing for all aspects of their identities when dealing with discrimination. They affirm their identity as a family with multiple intersections, yet also protect themselves from any ambiguity regarding their relationship.

'She [healthcare professional] asked who was Mum, and we said both of us, and we said after that she's adopted, and that is something that we automatically say anyway. It's just easier because it stops further questions...and because of the reactions that we had in the past.' Sarah

The complexity of intersectional play of adoption (and lack of understanding) in tandem with a heteronormative environment, led to challenges experienced by Harriet with regards to terminology (see 4.4) used by healthcare professionals within healthcare settings.

'We always hear the terms 'real mum', 'birth mum', 'biological mum', 'Who is mum?' But the one woman in the Walk-In Centre, she just said "well how can you both be mum?" ... and I said "because we are. He's adopted" and she said "so which one is the mum?" and I said "well neither of us are his biological mum." and we had to use those words because she couldn't get it.' Harriet

'We have been treated differently as a family. Whether that's because we're two women or because our children are adopted. It's sometimes hard to tell which one is which. Y'know when people refer to their 'real' parents rather than us.' Sarah

Sarah and Harriet both felt, however, that they were treated differently because they believed that people remembered them because they were lesbian, adoptive parents, rather than any other characteristic. Therefore it is their 'otherness' that has become their defining characteristic, rather than them being viewed in a heteronormative manner.

'I think we've maybe been treated differently in the sense that sometimes people remember who we are, when I think maybe otherwise they

wouldn't. You can tell they're thinking, "It's the lesbian couple who adopted".' Sarah

Sarah and Harriet also commented on how healthcare professionals tend to direct questions to one parent over the other and do not often acknowledge them as co-parents, whereby they both equally share the child caring responsibilities (as previously discussed in 4.4.1). They also acknowledged that this may be due to whoever took adoption leave accepted more responsibility for attending regular appointments for the children's health, or gender stereotyping (see 3.3.2), and the need to ascribe a parent to a heteronormative 'mum' or 'dad' role could have created an imbalance.

'They do direct stuff to Sarah instead of me and if Courtney's sat on Sarah's knee when somebody walks in and I'm sat beside or I'm out getting a drink for us, then they'll assume that she's the mum. I think it has had an impact and I think there's other factors as well that have meant I have taken things on board more... because I was off on adoption leave first, I got to grips with the health stuff more quickly. But I think it probably has had an impact in that, in a health situation, they are not addressing us both equally... but I think in most situations where there is a heterosexual couple who are parents of the child with a similar condition to Courtney, the mum takes on a lot of the day-to-day stuff.' Harriet

4.6.1 Strategies to overcome navigating healthcare successfully with intersectional identities

Previous discussion has highlighted how Sarah and Harriet employed overt strategies such as 'outing' (see 4.4.2 and 4.4.3) and passive strategies such as

'hiding' their intersectionalities (4.4.3 and 4.6) in order to successfully navigate healthcare. Sarah discussed her need to protect the children due to her intersectional identity and the discrimination faced by the minority groups of being a lesbian, adopter and black. She acknowledged that she aimed to protect her children by purposely being deceitful and not disclosing the adoption unless necessary, so that they did not have to endure questioning, but she also acknowledged that this strategy could be detrimental to her children's wellbeing and sense of self.

'Is that even a relevant question to ask [why were they adopted?]. Is her birth history relevant at all when she is 7...and has come with a chest infection...or has an injury? It has stayed in our mind that this has happened and when we go to the hospital I automatically have a guard up, for example to see people that we don't know. She's got speciality teams that know her and we don't have to go through the rigmarole each time of...this is who we are...we adopted her..etc. But I still have my guard up when we have to see someone and we are going together knowing at some point it's going to come out. It's not a guard up because I'm ashamed of it, it's a guard because I want to protect the kids because I don't want them to turn around in a couple of years' time and go "why do we have to say that [that they are same-sex parents with adopted children] every time? Are we not a normal family?" Because we are a normal family. I guess for some people it's not...but then I've always maintained don't persecute my kids for something that you don't agree with [being gay and adoption] because it has nothing to do with them. The easier thing is to pretend that we did give birth to them...but if they're there...you don't want

them to feel shame...that we're ashamed of the fact that they're adopted...because we're not, we're very proud of how we got our children. But...we want to protect them, but to protect them we have to lie. About where they have come from. I don't want them to learn that they have to lie about who they are and where they have come from. Because you shouldn't have to.' Sarah

A further covert, protective strategy that was employed by the parents as a result of the intersectional oppressive practice, was that Harriet and Sarah felt that they would probably delay seeking medical advice if a particular healthcare professional was not on duty in their chosen primary care setting, due to how other professionals have made them feel as a result of the intersections within their identities. They also highlighted that they would want the healthcare professional to understand adoption and their family constellation; as previously discussed in relation to adoption competence (Goldberg *et al.*, 2019) in 4.5.1, 4.5.2, 4.5.3 and 4.5.4.

'If they read our file and they are substantive doctors and not locums it helps. But we make the effort now if the children have got to go to the doctor's... we ask if Dr xxxx is in and I would go for that person even if it's the next day as they understand the adoption and being gay... I think potentially I would probably wait' Harriet

Harriet employed a strategy of 'hiding' her intersections in order to have a better outcome when accessing healthcare for the children. It was noted previously (4.6), that Sarah 'hides' her race by not attending the consultation, however in

this case Harriet attended the consultation alone, therefore she 'hid' her relationship and therefore sexuality status. Harriet commented that when attending a health appointment on her own with Michael the questioning was different as she did not present as a lesbian couple with Sarah, therefore the intersections of her identity, being a lesbian and an adoptive parent, were not apparent. This is a feature of concern as the NHS is a universal service and families should not have to 'choose' which parent should attend a consultation to ensure that they feel that they are treated equally and free from discriminatory and oppressive practice. Harriet's encounter is an example of purposeful deception, but it should be acknowledged that it is forced upon due to potential negative attitudes that Harriet may get if she tells the truth. Therefore in utilising Harriet's own words, it is self-preservation, which is achieved by purposeful deception.

'The difference was that there was just me so suddenly all the issues disappeared because he was my son and we went through his birth history as if it were my history. And you almost can ignore it [the fact he's adopted] because it's not worth the hassle sometimes. You almost pretend...and you shouldn't have to pretend when they go...'giving birth...was it a normal delivery", "yes" because it's easier for him and it's easier for me and it's not going to affect the care that he's going to get. So if it's not going to affect it why do you need to know?! It's a self-preservation thing.' Harriet

4.6.2 Summary

This study has highlighted that intersectional play has a direct impact on the ability of lesbian parents to successfully navigate healthcare for their adopted

children. The intersectional play of being a lesbian parent, adopter and dual heritage increased the oppression and discrimination experienced by Sarah and Harriet. It can be deduced that if either of them felt ignored or vulnerable in relation to one or more of their intersections (such as identifying as being a lesbian, dual heritage or adoptive parent) this could have an impact upon their sense of self. For example, they may believe that they have been subjected to micro-aggressive behaviour within the situation that they have described and therefore their identity challenged. The same is also true in relation to their adopted children as they, and their parents, may feel a sense of invisibility in their intersected identities (Kerppola *et al.*, 2019), which could in turn affect their family identity and sense of self. The effects of intersectionality is also linked to 4.4.2.2 whereby there was positive intersectional play demonstrated with regards to the privilege of socioeconomic background and professional status, which resulted in a power rebalance.

4.7 Reflective imagery of lesbian parents and adoptive families

In order to allow a sense of identity and inclusion, a family must be able to see their constellation reflected before them in society. Within the context of this study, this can be considered in wall posters and the administrative forms used by institutions such as the NHS in England, which is a universal service and therefore is expected to be welcoming and to treat everyone equally and inclusively. However the findings from this study demonstrate that there remains a way to go before a same-sex family is reflected in the normative. As detailed in 2.7.3, previous research (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) notes that the rhetoric of institutional forms and documents often showcases the attitudes of the

establishment or organisation. The bureaucratic systems employed within healthcare are inflexible and outdated (McNair *et al.*, 2008; Chapman *et al.*, 2012a). The overall aim with regards to transforming bureaucracy is that it should be implemented to enhance the environment and make it more supportive for lesbian parents (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton 2001).

Sarah and Harriet experienced the same frustrations felt by the participants in previous studies (Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) as their family constellation was not recognised within bureaucracy and it is widely admitted that the health system still use 'mother' and 'father' within their administrative forms. This is in breach of the Equality Act (2010), as omission of the family constellation due to sexuality, in the forms of a state agency, is a form of discrimination. As discussed in 2.7.3, Chapman *et al.*, (2012a) commented that participants in their study discussed how they 'take it in turns to cross out mother and put the other parent in' (p.1132) and Mikhailovich, Martin and Lawton (2001) highlight that medical documentation should not assume heterosexuality or that the only legitimate family type is the nuclear family. Sadly, this occurrence is still happening in England. The participants in this study, similarly to McNair *et al.*, (2008) felt that navigating the bureaucracy of the healthcare system was a challenge and it was mostly related to the non-recognition of the existence of lesbian-parented families as there was not 'a box they could tick on the form'. Harriet explained that one of the issues of the forms utilised by healthcare professionals in England, is that they do not use gender neutral terminology such as 'parent' or

'partner'. Therefore universal heterosexuality is assumed and forms are exclusive to heterosexual parented families and therefore are not inclusive of diversity.

'We had to register him [Michael] at reception [primary care setting] and it [the form] had the usual...mums name...dads name. So we crossed out dad and just put mum.' Sarah

Harriet described how she had completed the patient registration form in a secondary care setting. However, she noted that the issue was not just regarding the parental sexuality, but also the adoption status of the child. This highlighted that the current NHS system and processes are unable to recognise both same-sex parents and adopted children due to universal assumptions surrounding what a 'normal' family looks like, and, as noted in 4.6, families experience oppression and discrimination twice, based upon the two intersections. Therefore just as staff attitudes are affected by a deviation away from a societal norm, so too are institutional forms. It should be noted that even if people, as Harriet discusses below, manually change the form it could be presumed that the databases, in to which the form data is inputted, do not acknowledge these other categories so this data still cannot be logged correctly.

'[when the form states] mother and father! We crossed it out and put parent and parent and we actually made a change to the form. I mean in that respect we have crossed out father and put parents...and the way they do the form...a parent isn't an option on there... or to say is this child adopted and I think that should be on there.' Harriet

Harriet then continued with a statement which further endorses the confusion which surrounds some healthcare professionals of the viability of a family that deviates away from the societal norm (see 3.3.3). The below example shows discrimination with regards to the administrative form not being inclusive and oppression on the part of the healthcare professional as they made no attempt to amend the form to reflect the family dynamic.

'They had a form at the hospital...where we just got put as adoptive parents, we don't get full status as parents...as if there's another parent somewhere hiding or there's another option. They've asked mums name and dad's name. We've said there isn't a dad and given both of our names so they've just put one mums name down and haven't bothered filling in the rest of it! Just literally left it empty coz [sic] that was too tricky.'

Harriet

The insistence that Harriet and Sarah were named as adoptive parents (as opposed to parents) further supports an ideation that adoption is not 'normal'. In addition as neither of them identified as 'male' and therefore were not 'Dad', one of them was completely ignored as part of the family. This viewpoint is mirrored by Hayman, Wilkes, Halcomb and Jackson (2013) and Appelgren-Engstrom, Borneskog and Almqvist (2019) who discuss terminology such as sister or friend being used by healthcare professionals when referring to lesbian parents and questioning over the whereabouts of the father, all leading to a sense of alienation and disenfranchisement of the lesbian parent (Kelsall-Knight and Sudron, 2020). Health care professionals therefore must confidently

acknowledge the parents and therefore sexual orientation of those patients in their care (be it parent or child) in order to avoid causing confusion for children with regards to their family constellation, and potentially the family identity being discredited when they are accessing healthcare services.

In addition to administrative forms not being reflective of same-sex and adoptive families in this study, it was also apparent that images of families in healthcare were also not reflective. Harriet discussed images of lesbian adoptive families and the lack of visibility within healthcare settings.

'I don't think I've seen anything... and I think I would notice. But, I haven't seen anything that's LGBT purposefully inclusive... I find it pretty rare anywhere to see a lesbian couple with children depicted...and you do often see images that are one parent with a child or two parents of heterosexual families.' Harriet

She then continued to discuss how various consumer goods were steering their marketing to include same-sex families and also acknowledging parenthood within them. Harriet's shock at lesbian parents being portrayed in the mainstream media was evident when she stated that *'we actually rewound it and said that it couldn't be right'*. Sadly however she went on to say that imagery in healthcare settings, where she would attend with their children, still remain portraying families in a heteronormative way.

'McCain are doing good...and Vauxhall... but she was pregnant as she was taking her to the hospital so it was quite a positive one... we actually

rewound it and said that it couldn't be right... but that was about giving birth... adoption no. I mean when you're in waiting rooms... and then there's a picture of a family, it's never two women or two men with a child, it's always a man and a woman.' Harriet

Sarah, however has seen some positive imagery about same-sex couples in her General Practitioner's surgery.

'Specifically about adoption no, as in it doesn't say adoption...I have recently seen pictures of diverse families...that are portrayed as two women and children, two men and children and then mixed ethnicity and family diversity.' Sarah

What struck me with Sarah was that she has noticed that there were depictions of mixed heritage families, in addition to same-sex parent headed families. This strengthened my thinking that being in a marginalized group often allows you to 'see' the characteristics that determine you to be in the minority, whereas people who do not identify in that group may not acknowledge them. Visual representation of lesbian families was acknowledged by previous studies (Perrin and Kulkin, 1996; Mikhailovich, Martin and Lawton, 2001; McNair *et al.*, 2008; Rawsthorne, 2009 and Chapman *et al.*, 2012a; Andersen *et al.*, 2017) and it was determined that displays reflecting family diversity could aid in the acceptance of lesbian parented families and lesbian parents may feel more supported in healthcare settings.

4.7.1 Summary

In summary, the theme of reflective imagery of lesbian parents and adoptive families in healthcare settings has shown how lesbian adoptive mothers 'seek out' reflective imagery, be that through institutional forms recognising their family constellation or posters on the wall depicting diverse families. This study has highlighted that in order for lesbian parents and their adopted children to recognise themselves in healthcare bureaucracy and in poster representation, healthcare institutions must become more inclusive. Healthcare institutions have a legal obligation due to the Equality Act (2010) to be inclusive, as arguably, discrimination can be through omission as well as through direct active action. An inclusive environment could be achieved by receiving training specific to the needs of lesbian and adoptive families, updating forms to gender neutral terminology such as through the use of 'parent' rather than 'mother' and 'father' and also by providing inclusive symbols (such as the NHS Rainbow Badge¹⁰) that depicts the diverse population served.

4.8 Professional expectations

Professional expectations was recognised as a theme because overall three of the participants, including myself, worked for the National Health Service in varying roles. Therefore there was evidently an increased knowledge of professional codes of practice, alongside the standards expected of all healthcare professionals, which had an impact on service expectation. This study, throughout all of the data, has highlighted that, despite professional standards being in place, Harriet and Sarah sometimes felt that professional

¹⁰ NHS rainbow badges are a national initiative which originated in Evelina London Children's Hospital to make a positive difference to LGBT people and their families by promoting inclusion (NHS Rainbow Badges | St Guy's and St Thomas' NHS Foundation Trust, Evelina London, 2020).

standards were not always adhered to as they were subjected to discriminatory practices, which ultimately contravened the inclusiveness of the National Health Service in England. It should be noted that working in an anti-oppressive, non-discriminatory way is a requirement of regulation of the professions and a requirement of the Equality Act (2010) and the protected characteristics related to it. Adoption is not a protected characteristic in the Equality Act (2010) and as such there is no legal protection for people with that characteristic, and therefore less understanding, as people do not have to legally understand adoption as there is no legal consequence to this type of discrimination. Harriet and Sarah highlighted that sometimes the healthcare professionals that they came into contact with lacked adoption competence (Goldberg *et al.*, 2019) as they had gaps in their knowledge in relation to health conditions and the long term effects of health related challenges associated with adopted and looked after children.

'The health visitor came [to the house]...she didn't really understand adoption. She couldn't get that [adoption] into her head, I mean in the sense of terminology and I don't think it was the fact that it was two women, [it] was adoption, because it was hard trying to get her to understand things like FAS [Foetal Alcohol Syndrome]. She didn't understand things like the fact that he [Michael] needed to have a blood test, because [of birth mother's history] he needed screening for hepatitis C or B...and I was pushing for an eye test and she said, "well I don't think that he needs one" but I said "well we've been told by a Paediatric Consultant that he needs an eye test"... and she couldn't understand that,

and I was like “well do a bit of research”... I mean we were educating her more than anything else.’ Sarah

‘I don’t expect them [health care professionals] to have a lot of adopted children [as their patients] but it should be something where you as a person [who is] not in the medical professional shouldn’t have to try to educate them about what they’re supposed to be doing or there should be something where they should be able to easily access what they’re supposed to do.’ Harriet

Juxtaposed to the above examples within this theme, good practice was noted at times. Harriet discussed an anaesthetist who was a *‘really important piece of the jigsaw’* and a surgeon that made her and Sarah feel as if Courtney was *‘in safe hands’*. Having a child in hospital can be a solitary experience and it is also a confusing time for parents as they may have an intrinsic turmoil surrounding their role in caring for their sick child (Entwistle and Watt, 2006; Thompson, 2007; Smith, Swallow, and Coyne, 2015). Therefore, increasing the involvement of parents with regards to decision making and completion of care giving for their children, leads to an increase in parental satisfaction and strengthening of the role of parent, which in turn strengthens the familial identity (see 3.3.2 and 3.3.3).

‘There was this anaesthetist who was lovely... I think that relationship was very important, and I think one of the things which had a massive impact on us trusting him was that he never asked [who was her Mum] and he obviously had read the notes or talked to somebody, or had just worked

out the situation himself, acknowledging both of us all of the time and explained that when the surgeon came and we signed the consent that one of us could sign, or we could both sign. He explained stuff to us as if we were both parents, which it shouldn't really be a novelty, but it was.'

Harriet

'[the surgeon] waited to do the surgery...until we were legally her parents because he wanted to give us that right to choose whether she had surgery or not. Rather than the social worker just signing a piece of paper and not really looking into whether it was good or bad...it [the consent form] was just a piece of paper to them. As a family we've been treated exactly the same as he treats everyone else and with consideration for the children and the terminology that he uses.' Harriet

Sarah remembered the inclusive nature of the surgeon when he came to see her and Harriet whilst Courtney was in the recovery room after her operation, and how the words that he used to describe them gave a sense of pride in her family as he approached them with certainty.

'He said "There's the two mums I've been looking for. Shall we walk and talk?"... it was very normal and he's always been inclusive and great with the kids. I think he's helped restore their faith in healthcare.' Sarah

In addition Harriet felt that a doctor at their local GP surgery was inclusive to the whole family. She also practiced family centred care (Shields, 2015) thereby placing the child in the centre of their care and ensuring the needs and

dynamics of the family were recognised. Shields *et al.*, (2012), Nursing and Midwifery Council (2015) and Health and Care Professions Council (2014) all detail the professional responsibility to accept and treat people inclusively, as failure to do this could lead to insufficient health care being provided to the patient and thus if the professional was reported to the governing body and the complaint upheld, they could be deregistered from the profession.

'One of the best relationships that we've had is with one of the female doctors at our local surgery. She's all about the child and so she puts us all together [in the consultation] and knows us quite well. She's really good and really respectful.' Harriet

An awareness of professional roles and attributes ascribed to healthcare roles was a discussion point which was explored by one participant. Harriet focused on the healthcare professionals being in a position of trust and the disappointment when they did not recognise the privilege of the position that they were in. Goold (2002) commented that recognition of trust as a sociological construct refers to the expectation of people, typically for goodwill, advocacy, and competence. Therefore past experiences and other forms of knowledge (such as belonging to a same or similar profession, such as the educational level of Harriet, see 4.4.2.2) influence the degree of trust that is expected to be bestowed upon a person. Harriet recognised that the hospital was a safe place for their family due to their past experiences, therefore she had a predetermined level of trust that she expected to bestow onto a healthcare professional, therefore there was an expectation of a reciprocal understanding of the privilege of position from the healthcare professional.

'This person [healthcare professional] is in a position of trust and we have to listen to them... our kids very much feel at home in the hospital setting for one reason or another....and I think it just questioned that safety in terms of these people are supposed to keep us safe...it was that vulnerability in Courtney and Michael in terms of "what are you gonna do as they've just said I'm a foster kid?" I think it's just, for her [doctor] I don't think it was a normal family structure and I think she didn't know how to deal with it. She was just so abrupt and lacked compassion and was so uncaring....whatever her feelings...it didn't come across that she was in a caring profession and there to make things ok for the children... with them having additional health needs we need to be aware that they're not fearful of professionals. It's [the hospital] going to be a part of their life so we make it a fun place to go and it's safe to be and everyone is there that's going to look after you...and she was the complete opposite of what they have come to believe is a safe place.' Harriet

4.8.1 Summary

In summary, the theme of professional expectations has highlighted that healthcare professionals have a legal and ethical requirement through their professional standards (GMC, 2014; HCPC, 2014; NMC, 2015) to provide care which is aligned to the Equality Act (2010) in order to ensure that all families are treated with respect and dignity and not discriminated against on account of their protected characteristics. This is echoed in the NHS values and the NHS Constitution (DoH, 2015a) which comments that the NHS aspires to the highest standards of professionalism through, but not limited to, respect and dignity and the patient will be central to the services provided. The examples provided

throughout this theme have highlighted that whilst Sarah and Harriet have been a party to some outstanding interactions with healthcare professionals, they have also been subjected to behaviour from healthcare professionals, who have acted unlawfully and contrary to their professional standards. This study has highlighted that whilst there has been some excellent examples of inclusive practice, there still remains a rhetoric of heteronormativity (see 4.4) and lack of understanding of adoption (see 4.5) in healthcare and the differences between being in foster care which is temporary, as opposed to being adopted which is the permanent transfer of parental responsibility (see 2.3.1 and 2.3.2), as identified by the discriminatory attitudes exposed in this study, which needs to be challenged in line with professional expectations of healthcare professionals.

Chapter 5: Conclusions

In this chapter I will begin by summarising the main findings of the study before moving on to detail the original contributions to knowledge, methodology and professional practice that have been provided by this study, before moving on to consider the recommendations for practice. The latter part will reflect on limitations of the study and opportunities for further research, before summarising esteem factors pertaining to the thesis and final conclusions.

5.1 Conclusion of main findings

This study aimed to achieve an understanding of how lesbian mothers in same-sex relationships perceive and understand their experiences when accessing healthcare for their adopted children, and the intersectional play concerning lesbian parents and adoption. The themes that were determined from the study all had equal importance and relevance to the lesbian mothers and highlighted

current practices across healthcare settings which are being experienced by this group of people.

The determined themes, which are detailed in section 4.3, vary between being generalizable to all adopters, and specific (or magnified) for lesbian adopters. The discussion surrounding the theme of encountering healthcare settings and professionals and having an 'adopted' status are more generalizable to people who have adopted. There is only one theme which is specific to only lesbian parents and that is navigating heteronormativity. England legalised adoption for people who identify as LGBT in 2005, yet the participants encountered micro-aggressions, institutional heteronormativity and behaviour which was discriminatory, as opposed to professional. England has a diverse population demographic with multiple intersections and all healthcare professionals should be able to communicate appropriately and inclusively with all members of the public that they have contact with. Questioning around parentage was more evident if both lesbian parents attended the health consultation, if only one parent attended then it was rarely commented on unless the child had a complaint that was related to the early life experiences (such as Foetal Alcohol Spectrum Disorder). Whilst there were commonalities that many adopters may face, such as minimal imagery promoting adoptive families (or lesbian adoptive families), there was also the challenge of intersectional layering whereby the person was a mother, lesbian and dual heritage. Being an adoptive parent and/or occupational identity are also intersections within their own right, therefore the themes of reflective imagery and professional expectations could be generalizable due to the interplay of intersectionality.

In the majority of critical incidents shared by the participants there was a heteronormative view portrayed by the healthcare professionals and questioning over the whereabouts of the 'father', which appears to be a prominent feature in children's healthcare (Connell and Pearse, 2014; Appelgren Engstrom, Borneskog and Almqvist, 2019) and is coupled with heteronormative language. There was a deep sense of a lack of awareness of adoption, adoption competence (Goldberg et al., 2019) and the 'hidden history' of the children, coupled with their own professional expectations, which the mothers believed should have been acknowledged and the healthcare professionals receive training on and also offer further support to the families provided if necessary. There was no reflective imagery of their family constellation in healthcare, which could over time lead to an identity challenge and relied on the parent 'altering the form' to fit their constellation. Therefore it can also be deduced that the behaviours of the healthcare professionals are endorsed by the institutional imagery, such as forms and posters being heteronormative.

The intersection of being an adopted child was also noted in this study and the micro-aggressive behaviour such as dehumanised terminology and invasive questioning regarding birth history by healthcare professionals was apparent. Being an adopted child and having lesbian parents increased the micro-aggressions and therefore discriminatory treatment that the family were subjected to. This brings the question as to whether the legal status of 'adopted and looked after children' should be a protected characteristic in the Equality Act (2010) to ensure that their identity is protected and discriminatory attitudes towards them and their adopted families are made unlawful, especially when

considering the impact of inclusion of other intersections of their identity such as, but not limited to, race, gender and sexual minority parents.

The findings from this study show that whilst lesbian parents often have to tread a complex and heteronormative path within healthcare (Chapman *et al.*, 2012a; Kelsall-Knight and Sudron, 2020), there are pockets of positive affirmation of lesbian motherhood and these should be applauded and encouraged as 'gold standard' patient care. Finally, the study highlights that lesbian parents and their adopted children have a human right, legal position and expectation to be treated with respect and equality.

5.2 Original contribution of knowledge

This study has provided original contributions to knowledge in relation to understanding the topic of lesbian parents accessing healthcare for their adopted children and key surprises determined during data collection and analysis, methodology, professional practice.

5.2.1 Original contribution to the understanding of the topic

This study has provided a dialogue of the experiences of lesbian parents accessing healthcare for their adopted children, which has never been 'heard' in England prior to this study. Some of the study findings echoed literature that has previously been published, however none of this literature is British; this is the first British study. The term of 'hidden history' (as discussed in section 4.5.2) has been coined as new knowledge for adoption research. In addition, this study has highlighted the discrimination that adopters and adoptees face in English healthcare due to a lack of adoption competence (Goldberg *et al.*,

2019). Therefore this study has provided knowledge regarding the intersections of sexuality, parenthood and adoption.

5.2.1.1 Original contribution of key surprises determined during data collection and analysis

Undertaking data collection and analysis highlighted three situations which surprised me as a researcher. They were as follows: page 105 and the assumption made by a nurse to a child that the child had a father, despite the varying family constellations in the United Kingdom that exist away from the normative of having a mother and father, *“Oh, well done, you can tell Daddy all about it when you get home”*; page 109 the self-disclosure of sexuality in order to protect the healthcare professional, *“I think it is important to protect whoever you're interacting with... in this case the medical professional”*, and page 132 whereby the parent believed that they would be discriminated against due to the colour of their skin, *“look I'm not taking her to the doctor again because they have a habit of sectioning black people”*. These three situations surprised me as despite being an insider researcher, I had not knowingly experienced these situations before personally or professionally. Therefore this does highlight the limits of bias given peoples' experiences and actions are unique to their individual set of circumstances and, even though there may be some overlap as an inside researcher, in my role as a lesbian adoptive parent and registered nurse, differences in experiences will always remain. The pre-emptive strike of self-disclosure as a way of protecting healthcare professionals was unexpected and whilst it links into 'proud disclosure' (McNair *et al.*, 2008), it could also be seen as exulting power over a person due to a person making an empowering decision to share information, rather than it being gathered and them giving up the ownership of their identity and challenging patriarchy (Burr, 2003). I was abhorred by the comment regarding concerns over the colour of a person's skin

as The NHS Constitution (DoH, 2015a), The Equality Act (2010) and professional codes of conduct (GMC, 2014; HCPC, 2014; NMC, 2015) are in place to challenge, to hold professionals to account and to make poor treatment in healthcare due to someone's race (or any other protected characteristic) unlawful. However it is apparent that racist attitudes persist despite legal frameworks and professional codes.

5.2.2 Original contribution to the methodology

The utilisation of Narrative Inquiry with a three stage interview and the creation of a composite character couple has allowed anonymity to be maintained but has given 'life' to the stories that have been obtained. Data analysis was rooted within the combined models of Connelly and Clandinin (1990) and Webster and Mertova (2007) which allowed for 're-storying' and participant representation through the composite character couple. This approach allowed the stories of the participants to be powerful, yet protected, and lent itself to presenting adoption and lesbian research in a new way. The utilisation of an online platform (Skype) has made an original contribution to method as its flexible nature has demonstrated its efficacy in light of the Covid-19 pandemic with more research now needing to be done online. It is hoped that moving forward, more consideration will be taken by researchers in considering data collection tools which do not require face to face meetings.

5.2.3 Original contribution to professional practice

As detailed in Chapter 1, once the composite characters had been developed I wanted to utilise their presence further, therefore I wrote a children's book (Kelsall-Knight, in press). The 're-storying' layer within the book is one of positivity and inclusion and the ethnicities and genders depicted within the book

are representative of the participants within this study. The professionals shown within the book are purposely gendered to challenge gender-stereotyping within professions. The book is based upon a same-sex parented adoptive family being part of the normative and what children and their parents should expect when accessing healthcare, therefore it evidences good practice and as such can be used in training healthcare professionals. The aim of the children's book is that it can be used as an educational tool to showcase diverse families to people of all ages and it can also be used by children who have same-sex parents that are attending healthcare settings to allow them to visualise themselves and to be represented. Whilst the book does not state that the children are adopted, parents and professionals could use the book as a tool and alter the identity to allow all children and families to be represented through it. There are no children's books in the worldwide market that showcases the above details of diversity and healthcare setting. It has been accepted for publication with a tentative release date of December 2020.

In addition, a 'toolkit' checklist of inclusive considerations for utilisation by healthcare professionals with lesbian parented adoptive families has been compiled, which relates to adoption competence and positive acknowledgement and awareness of lesbian parents in healthcare (Appendix 6). This can be used in pre- and post-registration curricula and mandatory training as a gold standard to acknowledging this family constellation. This study has highlighted that healthcare practice needs to be more inclusive by adapting the administrative forms to depict varying family constellations, utilising inclusive and appropriate terminology with an understanding of adoption competence (Goldberg *et al*; 2019), the differences between being in foster care as opposed to being

adopted (see 2.3.1) and by providing positive imagery. Whilst many NHS Trusts in England have adopted the Rainbow badge project (see 4.7.1), a badge alone does not make an inclusive environment as it does not alter the attitudes of all healthcare professionals. Section 5.3 will detail proposals for an inclusive healthcare environment.

5.3 Recommendations for practice

Healthcare professionals must be transformative and provide optimum care for their patients and families. As a registered children's nurse and parent I am aware of how the stories told by the composite character couple could have a long term impact on children and their families. Whilst the participants of this study all had commonalities within their experiences, they all viewed the experiences through differing eyes, therefore no story or perspective was the same.

Viewing the world of accessing healthcare through the eyes of a lesbian parent should be an enlightening process for those who are not from the LGBT community. Hearing the stories should draw practitioners, educators, service directors, policy makers and learners into creating a space that is inclusive and safe and whereby the communities which they serve are represented in terminology and imagery. A space which upholds the values of the NHS and the professional codes of conduct.

The recommendations are:

- A 'toolkit' to help provide structured teaching surrounding the 'gold standard' approach for best practice and challenges experienced when accessing healthcare for lesbian parents and also adopters. This would include the checklist in Appendix 5. This 'checklist', accompanied with

training on the experiences of LGBT people in healthcare (Stonewall, 2008) early life experiences of adopted children and the importance of trauma informed care (Menschner and Maul, 2016; The Kings Fund, 2020) would also allow for an increase in collaborative working with social work, medical, nursing and allied health professional colleagues.

- To address heteronormative oppression within healthcare settings, there should be a creation of safe spaces which incorporate reflective imagery and positive, ally ship attitudes of staff for people from the LGBT community. The staff allies may be diversity or inclusivity champions who achieve the gold standard of care and disseminate their knowledge and the training materials to the wider staff group, or they could be other staff members who feel able to empower other members of the healthcare professions to develop relationships through interpersonal skills and advocacy. The 'spaces' are unlikely to be physical structures, but instead an inclusive environment.
- In addition to a safe LGBT space, there is also a need for an inclusive space for people from the adoption community. Adoption competence (Goldberg *et al.*, 2019) is vital, alongside an appreciation of hidden history. In addition it is imperative that family centred care is practiced, so that the children accessing healthcare with their parents remain at the centre of their health journey. This includes an improved sharing of information across agencies (Local Authority and NHS) to address the issue of the 'hidden history'.
- The children's book (Kelsall-Knight, in press) (see 5.2.3), which is an output of this study, could be adopted by healthcare, social care and

education settings so that children with lesbian parents can see their family structure reflected in the normative.

- Inclusion of LGBT and adoption competence training, including the utilisation of diverse family children's books, should be mandatory in healthcare settings as well as undergraduate and postgraduate curricula for social work, nursing, medicine and allied health.
- The government should consider 'adopted and looked after children' to be included as a protected characteristic in the Equality Act (2010) in light of the intersectional play and therefore increase in oppression and discrimination that looked after and adopted people face.

5.4 Limitations of the study and further research

This study has considered the stories of lesbian adoptive mothers only and the dissemination of its findings has been ongoing via conferences, publications and small group teachings. Whilst the narratives in this study provided a rich source of data about the parents' perspective of accessing healthcare for their adopted children, the research is limited as the information is only obtained from one section of the LGBT community. Therefore the perspectives of gay men, bisexual or transgender people have not been heard, nor those from the 'silent' (see 2.9) LGBT community. Consideration was given at the stage of the research proposal with regards to seeking the perspectives of gay men, bisexual and transgender people, however it was felt not possible due to size of the project and the timeframe available, particularly if contemplating a representative sample and undertaking a comparative study of the experiences of different groups. The sample size of this study was six, whilst this was not a negative due to the methodology chosen, it may be useful to conduct further research with a larger sample size or more cluster samples and differing

methodology (such as a large scale survey) to allow for a generalisation of findings, whilst acknowledging that the data may not be as rich. With this in mind, a consideration of the limitations of the composite character couple (see 4.3) and a reduction of participant characteristics that could be reflected within the couple should be acknowledged. In addition, further research should be undertaken to gain the perspectives of all members of the LGBT community in accessing healthcare for their biological and non-biological children to gain an awareness of the level of oppression that exists between the varying intersectional identities.

Another consideration of the study was that all the participants reside in England. The NHS provides healthcare across the UK, however, despite a national request for participants, no participants were recruited from Wales, Scotland or Northern Ireland. Therefore it is not possible to determine the experiences of lesbian parents of accessing healthcare for their adopted children across the wider UK.

5.5 Esteem factors pertaining to the thesis

This study has had, to date, two papers accepted for publication with the Journal of Nursing Children and Young People (Appendices 4 and 6). In addition I presented the findings via a webinar for AdoptionUK and have also provided a 'talking head' of the findings for midwifery students at Coventry University. Lastly, this study won the Nursing Children and Young People, supported by Royal College of Nursing's (RCN) Research in Child Health community (RiCH) research award for 2019-2020.

5.6 Final conclusions

The aims of the study (see 2.10) were to explore how lesbian parents describe their experiences of healthcare consultations for their adopted children in England; how the family unit, featuring lesbian parents and adopted children, is acknowledged within the healthcare journey by staff and institutional bureaucracy and imagery, and the perceptions of lesbian parents of accessing healthcare for their adopted children. All of these aims have been met and it has been determined that the social construction of a family is dependent upon peoples own experiences and understanding of the term family, therefore discrimination is apparent for adoptive families due to the family structure being a deviation away from the 'norm'. It is unacceptable and unlawful that heteronormative ideation persists in relation to sexuality and race within the NHS in the context of being a decade on from the Equality Act (2010). The treatment of these children and their adoptive families is potentially harmful to their mental wellbeing, sense of self and sense of security in their adoptive family life, therefore it can be argued that this is potentially a form of discrimination and oppression that must be recognised and addressed if necessary through reform and addition to the existing law; 'looked after and/or adopted' should therefore be considered for inclusion as a protected characteristic in the Equality Act (2010).

The study showed that the parents placed the children at the heart of their healthcare; this needs to be reciprocated by healthcare professionals so that family centred care and trauma informed care is practised. In addition, the wellbeing of the adoptive parents should also be considered, which can be

addressed by professionals being adoption competent (Goldberg *et al.*, 2019)
and aware of the hidden history.

Epilogue

This study has been significant in my practice as a children's nurse, educator, researcher and mother. Going through adolescence in the 1990s in England, I was educated in the era of Section 28. At the time of my own 'coming out', I had heard from various media outlets and other people that I was abnormal, it was 'unnatural' and I would never be happy. There was no legal recognition of same-sex relationships, so I believed that I was destined to live in the 'closet', as I thought it would have been easier to 'pretend' that I was happy, in a relationship with a man, and to be the 'norm'. In 2008, I met my best friend and knew that I could only be happy if I could be myself. I married her in 2010. We became parents first in 2013 and then in 2015. It was at this point, as the intersections of my identity increased to being a lesbian and an adoptive parent, that it became apparent the healthcare system that I worked in was not as inclusive as I thought it was. The spark was lit.

The doctoral journey has been tumultuous, overwhelming at times and euphoric at others. This thesis is a culmination of five years of self-reflection and 'hearing' the stories of others. There were times whereby I have intrinsically struggled with the dichotomy of professional expectation and myself as both a person and registered nurse in the discussions, as the participants told of their dismay of their treatment by healthcare professionals. The healthcare professionals that I share a profession with; my friends and comrades. The latter part of the journey has been marred by a global pandemic, which has shifted working patterns and roles significantly. I now find myself working full-time, completing a doctorate part time and home-schooling my children full-time. There has also been an overwhelming sense of pride as my study has

been recognised and awarded by the RCN and I have had a children's book (Kelsall-Knight, in press) accepted for publication.

I hope that as you read this thesis you can hear the experiences that the participants have endured and it enables you to reflect on your own practice, in whatever discipline it may be.

As a final thought I would like to share an additional part of my life with you, as a culmination of my journey, my own parallel of education which I encountered whilst trying to 'make sense' of my sexuality. I received my Advanced Level results in 2001; CDE. My university of choice to study Nursing wanted CCC. I telephoned them and was told that the Nursing Lead would call me back to say whether they would accept my grades. It was unlikely. Ninety minutes later she called. She asked me what had happened in my exams as my grades were nowhere near the predictions. I told her that I chose the wrong subjects, I chose what I thought I should do for my Advanced Levels, not what I wanted to do. I told her that I had tried, I had worked hard, but whilst my heart was in a Nursing degree, it was not in my Advanced level subjects. If I had my time again, I would have chosen what made me happy, the subjects that I felt passionate about. She asked me what I would do if she offered me a place, given that my grades were so low. I told her that if she believed in me, then I would not let her down. Every time I self-doubted I would push myself, I would ask for help and I would strive to be best children's nurse that I could be. She gave me a place and I graduated in 2004 with a 2:1 honours degree.

In 2004, as I completed my degree I went to see the Nursing Lead to thank her for believing in me. I told her that I had always believed deep down that I was meant to be a Nurse and I came into Nursing to make a difference, no matter how small, to people's lives. I promised that I would do my best to advocate for children and their families, to ensure that they received the best care available. If they did not receive that care, then I would empower them, advocate and try my hardest to hear them and make the change.

To this day, as this thesis stands testament to, I have stood by my word.

Be who you want to be, not what others want to see.

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Appendices

Appendix 1: Data extraction table

Author, year and country of origin	Aim	Sample	Design	Key Findings	Key Recommendations
Perrin and Kulkin (1996) USA	Describe the experiences of LG parents and their children in the paediatric healthcare system	255 responses. Lesbian mothers 84%, gay fathers 11%. Other 5% Children aged between <1 and 20 years	Exploratory Quantitative study. Questionnaire. Open ended questions and demographics. 2 mailings – 1 to a community centre mailing list (n=202) (no knowledge of sexuality of subjects) – 87 returned (43%). 1 to newsletter for LG rights group (n=2045) – 168 returned (8%) Responses coded and tabulated.	88% had positive experience in paediatric care. 75% positive in general clinics and ED. 78% positive experience in hospital. Problems arose for 38% in paediatric care, 53% in clinics, 39% hospitalized care. When asked about negatives, many reported lack of fair service in health services including 40% exclusion of non-biological parents, 33% issues with sexual orientation and family dynamic. Lack of understanding of same-sex parents and homophobia.	Changes to be made to environment. No assumption over gender (especially on forms) and family dynamic. Supportive literature in clinic area showing acceptance of same-sex families. Acknowledgement of both parents. Supportive conversations regarding same-sex parenting and emotional support for parents and children.
Mikhailovich, Martin and Lawton (2001) Australia	Investigates the experiences of LG parents seeking health care for their children in the	92 responses Lesbian mothers 82.6%, gay father 5.4%. Other 12%	Quantitative. Grounded theory. Questionnaire distributed with web survey also available (n=400) 23% response. 2 questions about	Satisfaction. 89% with GP, 62% paediatrician, 61% ED, 60% hospitalised care. Dissatisfaction. 16% ED, 11% paediatrician, 11% hospitalised care.	No assumption over sexual orientation of parents and family dynamic. Use of inclusive language and appropriate inclusive forms/documents. Education for healthcare providers about LG issues.

Australian medical system	167 children aged between 6 weeks to 36 years.	satisfaction of care and 7 open-ended about experiences. SPSS used for analysis.	27% suffered discrimination and inappropriate questions. 76% had no problems with disclosure of orientation. Results gained via thematic analysis based upon techniques of grounded theory.
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McNair et al (2008) Australia	Explore how lesbian parents negotiate the healthcare system	20 families. 36 lesbian mothers, parenting 43 children aged between 2 months and 38 years (20 of these children participated in the study) 3 grandparents and 2 donor/fathers interviewed. Diverse ethnicities – 11 Anglo-Australian, 2 indigenous, 8 European, 2 Asian, 1 Latino	Qualitative. Grounded theory. Snowball sampling then theoretical sampling to vary diversity. One indepth interview per family. Audiotaped and transcribed. Constant comparative methods of grounded theory, Coded using N-Vivo Positive and negative experiences coded into clusters	Two themes identified. 1)Experiences in the healthcare system. Lack of recognition of family dynamic and knowledge of legal issues. Heterocentric attitudes although not homophobia. Overcome by parents displaying united front and protective strategies, normalising family. 2)Disclosure of parental sexuality. Did not disclose to ‘protect’ children. One parent self-excluded from consultation. Others ‘proud’ and displayed a united front, honest and reduced confusion of healthcare providers.	Sexual orientation should be seen as a context driven and variable viewpoint. Healthcare providers should not make assumption about orientation. Clarify relationship if two women present with a child. Ensure forms and documents are not heterocentric. Increase awareness and education of same-sex families for healthcare providers.
Rawsthorne, M (2009) Australia	Examine how lesbian parented families can be supported in health care	17 families. 21 lesbian mothers. Children aged between pre-	Qualitative. Possibly phenomenology although not explicitly stated.	Majority had positive experiences. Children were recognised within the family dynamic as was the same-sex partnership/parenting. Some	Formal services such as healthcare could provide support groups to reduce isolation and awareness of same-sex families.

		school to teenagers. 7 one-child families. 8 had two-child families. 2 families had more than two children.	Snowball sampling. Semi-structured interviews. Thematic analysis using N-Vivo.	instances of heterosexist assumptions about family dynamic.	
Chapman et al (2012a) Australia	Explore the experiences of LGT families accessing health care for their children	11 LGT parents 7 lesbian couples 1 gay couple 3 couples where 1 partner was transgender 16 children parented aged between 1 and 20 years	Descriptive, exploratory qualitative study. Semi-structured open-ended face to face questioned interviews. Questions derived from aims of the study. Recruited via leaflet drop and flyers at a LG event. Further snowball sampling. Thematic analysis coded via qualitative descriptive framework.	Themes were managing healthcare experiences, attitudes and transforming bureaucracies. Many reported negative interactions within healthcare including exclusion of a parent, a need to disclose their sexual orientation, confusion over family dynamic and the assumption that all people are heterosexual.	Need for provision of forms/documents that are non-gendered and non-heterosexist. Create an open and inclusive environment for LGT families and educate healthcare providers on LGT issues and awareness. Acknowledgement of both parents in the care of their child.

Malmquist and Zetterqvist Nelson (2013) Sweden	Efforts to maintain a 'just great' story: Lesbian parents' talk about encounters with professionals in fertility clinics and maternal and child healthcare services	109 families expressed interest, 51 were selected with even geographical spread to participate. 51 families with 96 interviewees 45 interviews had two mothers participating, 6 interviews had one mother participating	Qualitative. Semi-structured interviews Content analysis and index of content of entire body of transcription determined commonalities. Purposive sampling	Two interpretative repertoires: 'Just great' repertoire – shapes a broad picture of positive, joyful and uncomplicated journeys towards parenthood which was depicted when encountering maternal and child healthcare services, alongside problematic and inadequate treatment. 'heteronormative issues' repertoire – highlights difficulties related to family formation However both repertoires were often incorporated into each other. Discussion is mostly focused around pregnancy and the maternity unit, there is minimal discussion of accessing child healthcare past the neonatal stage.	Professional training of all healthcare providers should include education on how to provide informed and competent treatment of minority patient groups.
Andersen, et al., (2017)	To describe LGB parents'	14 participants	Qualitative inductive design.	Two themes identified:	Child health nurses should work with the family to provide best

Sweden	experiences of nurses' attitudes in child healthcare	<p>11 mothers</p> <p>3 fathers</p> <p>1 family of 3 adults identified as bisexual. All other parents were gay or lesbian.</p> <p>Aged 33-48 years old</p> <p>Children ages ranged from 2 months to 5 years.</p>	<p>Semi-structured interviews</p> <p>Analysed using qualitative content analysis.</p>	<p>1)'Sense of marginalisation' – included heteronormative attitudes from nurses led to parents feeling alienated.</p> <p>2)'Being respected for who you are' – included experiences of being respected and included at child health appointments.</p>	care for the child. Tailor terminology and language in written material to meet the needs and inclusion of minority groups.
<p>Appelgren-Engstrom, Borneskog and Almqvist, (2019)</p> <p>Sweden</p>	To get a deeper understanding of how mothers in same-sex relationships think and reason about their parenthood in terms of gender equality, and how they experience early parental	<p>20 women</p> <p>Aged 24-42 years old</p> <p>Children aged 1-3 years old</p>	<p>Qualitative. Grounded theory.</p> <p>Open ended interview questions originating from the research questions and comprising themes of planning for parenthood and parental support.</p>	<p>A core category of 'same-sex mothers request professional support to achieve equal parenthood' with categories linked to it, which were equality in everyday life, (such as sharing parental leave), diversity in mother and attachment (attachment through breastfeeding and being physically close), justification of the family</p>	<p>Encounters and support from child health professionals must be improved. Health care professionals should be aware of diverse families and not make heteronormative assumptions. Inclusive and supportive parental groups should be offered. Network of same-sex parents to be created.</p>

	support from child healthcare professionals		Comparative analysis with open, axial and selective coding.	structure (acknowledging both mothers and terminology used), ambivalent thoughts about their child's future (fear of prejudice and discrimination) and a special need for networking and request for professional support (support from child health professionals)	
Kerppola et al., (2019) Finland	Describe empowerment in maternity and child healthcare from the perspective of self-identified LGBTQ parents in Finland	22 parents 1 transgender 1 bisexual 2 non-binary 11 non-biological parents Child ages 0-16 years	Qualitative open ended question interviews Inductive content analysis	3 core categories: 1)recognition and acknowledgement of being a parent. 2)working together as co-parents and recognised in healthcare as such. 3)equitable care – having trust in services and the health care professionals knowledge of the needs of the family	Need for inclusive terminology in documentation and in conversation to include both parent and a recognition of LGBTQ families.
Goldberg et al., (2019) USA	Lesbian, Gay, and Heterosexual Adoptive Parents' Experiences with Pediatricians: A	129 families (224 parents) 42 lesbian mother families	Mixed methods exploratory study Generalizing Estimation Equations (GEE) to	Parents did not expect their paediatrician to be a source of adoption expertise, but they were disappointed when doctors did not take the	Professionals to develop adoption competence by engaging with national adoption standards of care.

Mixed-Methods Study	36 gay father families	determine if family context variables, child characteristics and adoption context predict whether parents discuss adoption with paediatricians and whether they feel that paediatricians understand adoption.	adoption context into account when providing medical treatment.	Pediatricians should be sensitive to a child and their history and know how to provide referrals for further support.
	51 heterosexual families		Emergence of the need for adoption competence.	Environment should encourage and support adoptive parents and their families.
	Parents surveyed 8 years after adopting their first child.			More indepth research needed, specifically qualitative research with LGBT adopters.
	Purposive sampling	Qualitative examination of parents experiences with paediatricians.		

Appendix 2: Ethical Approval Letter

Date 21st December 2017

Lucille Kelsall Knight (Fiona Morgan)
University of Wolverhampton
FEHW

Dear Lucille Kelsall Knight (Fiona Morgan)

Re: Different constellation and shining stars: Lesbian parents' voices on accessing healthcare for their adopted children' submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your submission.

On review your Research Proposal was passed and given approval **Code 2 – Approved Subject to Conditions**. The conditions for Approval are below.

A. Researcher/Supervisor to Monitor. Please address the minor amendments detailed below. If this is student research, supervisors must ensure the minor amendments have been completed prior to commencement of data collection. A condition of this approval is that Supervisors must read through and check the revised applications and email a confirmation to fehethics@wlv.ac.uk to confirm they have occurred.

- We thought it might be useful to you to recommend that you state that people can use Skype OR FaceTime, as not everybody has Skype and they may wish to be included in your study.
- The information sheet should have the support agencies on it and please explain to your participants that you will collect demographic data from them and what this is going to be used for.
- You need to say within the information sheet that the interview or the skype interaction should take place in an area where the interview cannot be overheard.

- You say you will email participants the consent form, could you guarantee please that this is a secure email system when doing so.

Best wishes in the future.

Yours sincerely

H Paniagua

Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM

Chair – Ethics Panel

Appendix 3: Participants' quotations

Theme/Participant details	Participants 1 and 2 (couple)	Participants 3 and 4 (couple)	Participant 5	Participant 6
Navigating heteronormativity	<p><i>'It is only when we are together we have been asked that question [what is our relationship?], it's never when we've taken [the children] on our own'</i></p> <p><i>'...before we had the children it had been a long time since I had had to walk into a room and announce my sexuality. But since we've had the children, we walk in together and people go..."and you are?"..."we're both mum, we're together and this is our son"...and not that I have a problem with it, because I think it's actually important that the children see that this is the norm. This is normal for us.'</i></p>	<p><i>'I would say the majority of the time that we go together, people hardly ever read us as a family...usually they ask who's the mum and then we say we both are, or they just talk at one of us and then we say, "Oh, we're both their mums" or sometimes if we know it's going to be a short thing, like seeing a triage nurse, we just don't even bother explaining.'</i></p> <p><i>'I mean we're treated differently in the way that we're being questioned. My mum used to take me to the doctor...she's a single mum...there are things that she wouldn't have been asked about...for example like family history, how we were</i></p>	<p><i>'...in an ideal world, people would just automatically read two women with a child or children as both their mums but we're (as a society) nowhere near that point yet.'</i></p> <p><i>'I put myself fairly quickly. So that's just a natural tendency that I have to do.'</i></p> <p><i>'I think it's a consciousness [self-disclosure of sexuality] that I've developed over time and because I think it is important to protect whoever you're interacting with... in this case the medical professional...so to protect them from feeling awkward and saying the wrong things. I suppose in that way it</i></p>	<p><i>'This is one thing we struggle with in all professional settings...is people expect one of us to be 'the parent'... to have a more traditional...well I guess you could call it a more traditional family with 'who plays mum and who plays dad'...and we really parent very equally.'</i></p> <p><i>'I'm making a joke out of it now because I was trying to fit into this role and not that I was in a dad role, but if you're looking to put me in a box that was kind of what I did, and I think that is what they [health care professionals] try and do...like they have a framework, to hang you on.'</i></p>

		<p><i>conceived and that. I think we do get asked them because we're gay.'</i></p> <p><i>'You do get treated differently and I think if a straight couple had gone to the hospital... it would just be like 'yes there's Mum and Dad'. When we go and see [child's name] (Michael's biological brother) his ten year old sister doesn't know that she's adopted because they haven't told her yet and her parents are a man and a woman... and I think it just goes to show that she doesn't know because she hasn't had to know... They don't even get that question [who is the parent?] do they... where as we do.'</i></p> <p><i>'The GP [General Practitioner surgery] are</i></p>	<p><i>also protects them in front of [the children].'</i></p> <p><i>'I think I'm treated differently because I'm articulate and because I'm white and educated... it's also partially the medical professionals you end up seeing [in Ilkley]...will probably come from a higher socioeconomic background. So if they identify you in some way as 'like them' then I think you are often treated better. I feel like I've been treated with respect because of those different markers. And in some ways... [Ilkley] is a very liberal place so having self-identified myself as a lesbian and well-educated then I'm guessing...because my title is doctor [academic PhD]...if anything, that</i></p>	<p><i>'pre-empt the fact the people are not gonna [sic] get it'</i></p> <p><i>'So then when she finally found a vein, Courtney had done really well, this nurse said, "Oh, well done, you can tell Daddy all about it when you get home." ...Courtney sort of gave them a bit of a look and so I said, 'Well, actually, she doesn't have a dad, she's got two mums.' Then in that way where, I don't know why I always do this, I sort of always over explain. And you could tell this woman felt really embarrassed, but also didn't say much either.'</i></p> <p><i>'I said, "she doesn't know that you've got two mums and lots of us do have two mums like [friends names], and</i></p>
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		<p><i>really good. I think it's on her [Courtney's] file now that she's got two Mum's, so they don't ask any more. They've never asked but that's because Harriet told them and they've just been their brilliant from the beginning.'</i></p> <p><i>'It is the emergency ones [appointments] that aren't good...I still feel a little bit on edge... but because I work there now... I think it would be better... I'd wear my badge.'</i></p>	<p><i>aligns with the people they want to be with. So I think if we were a same-sex couple from a different background we may well be treated very differently or if we're living in a different location.'</i></p>	<p><i>that felt a bit weird didn't it that she said that." I tried to acknowledge it. But I do feel annoyed by it because these little moments chip away at their sense of self and security in having two mums.'</i></p>
<p>Navigating healthcare settings and professionals and having an 'adopted' status</p>	<p><i>'...We had to take Michael to the Children's Hospital and she was an Asian consultant and I will always remember her because he was sat there with us and she said "you know he has this condition and I think you need to ring his real mum because she has a</i></p>	<p><i>'We had to go to the one year health check for all looked after children and ...well considering they deal with adoption and adopted children they still don't get the terminology right... she said "what about her real mum?" and it's like</i></p>	<p><i>'She acts differently in doctors' offices... I don't know if it's because she had been with birth parents to the doctor's and so that was one of the differences in behaviour...and I think I even checked ahead of time to make sure that it was a female doctor but</i></p>	<p><i>'We don't want to have to explain their whole life story to everybody all the time but we do try to be quite open and ... but I think we probably end up doing that more than straight couples with adopted children because when they ask something like, "Who's</i></p>

	<p>right to know". I remember sat there thinking "no she lost that right the minute she laid a finger on him". But, irrespective, the point is it was in front of Michael and she referred to someone else as his parent, and he knows quite clearly he has us. He's never had another parent so his understanding of the term parent...and it almost implies that she [birth mother] has some hold over him still and that she can come at any point. How he interprets that...y'know it's little things like that that puts doubt in his mind as to...am I staying? But they [the healthcare professionals] don't really realise what damage they could be doing to his identity.'</p>	<p>really, it's not about that, we're her real mum.'</p> <p>'This lady [a nurse]...she could not get into her head which one of us was birth mum? "Which one of you is her biological mum? Which one of you is Mum? Who were her parents?" We had to explain that she's adopted, again, we constantly have to explain that she's adopted, [Courtney] was burning up and I was just saying 'forget about us, sort her out!' I was just saying 'how has her temperature got anything to do with genes?'</p> <p>'The main priority is [Courtney and Michael] and when we first had [them] we were proud parents...you're trying to establish that they are</p>	<p>she refused to let the female doctor see...so there was a lot of coaxing and I was trying to read a book with her...I think it might be a trigger [attending the doctors]...she becomes a different person in the doctor's office, like very shy or hides behind you and will be seeking attention. The difficulty is more in terms of how she reacts to that environment... you go to the GP and have a 10 minute appointment...and she's refusing to do something that's cutting into their time...so then they don't necessarily know how to respond... and some GP's are better at responding than others.'</p> <p>'I was angry about having to explain who</p>	<p>the mum?", ...you almost feel like we have to explain ourselves more and I don't know why. We could just say, "Yeah, we're both their mums", and leave it at that, but you feel like you have to blurt it all out so that they understand. I think there have been times in other situations, not in healthcare, where people have really not understood what we meant when we have said that we were two mums and really questioned us and undermined us, and you don't want that to happen in front of the children. I think sometimes people have said things like, "Oh, that's not possible, of course you both can't be their mum, who's the real mum?" I think you</p>
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	<p><i>'I guess people's understanding of adoption is then gonna [sic] have an impact on how they perceive our family. We went to the local hospital [Accident and Emergency department]...and saw a Registrar. Courtney had an injury...and we were taken through to one of the cubicles. I walked ahead first with Courtney and as we walked through, the curtain was abruptly pulled across in front of Sarah and Michael. Sarah opened the curtain and said "do you mind if we come in...we're part of the family?"...to which she [the Registrar] said in front of both children "well, who are you?"...and I said "I'm, his mum" and then she</i></p>	<p><i>your child and you're getting to know that child as well, and when you're trying to feel comfortable in being mum and Mummy... when you are feeling that...you forget that they're adopted. Then when you go in (to the healthcare setting) and they say 'well, who's mum?' it takes you right back... and you don't feel like you're important. It just makes you feel...who are you really? That's why it's nice when somebody understands it and reaffirms who you are... when someone questions [the parentage] it's not nice.'</i></p> <p><i>'We said you'll use this surname, it's not the legal one but it's the one it will be changed to [when the Adoption Order is made] and it</i></p>	<p><i>we were, but it's become the norm for us. She [Courtney] wasn't well and we were concerned for our child, so why are you asking me about who is Mum, you know it doesn't matter, the fact that we are both there and we are both her parents... and she is unwell and it felt like that wasn't at the forefront...we've brought her in and we want to know what we can do to make her feel better, not go over who gave birth to her because that's irrelevant!'</i></p> <p><i>'I think because they're adopted we often get asked things like, "Do you have parental responsibility, do you have a social worker or anyone else we should call?", which I</i></p>	<p><i>want to pre-empt that in a way. You have to explain all.'</i></p> <p><i>'I think when we first adopted them, we were definitely asked about things a lot more..."have you got it [the Adoption Order] sorted yet?" and we'd say "this is our social worker's phone number" when we'd ended up going to A&E. I think they [the healthcare professionals] said a lot more things like, "do they still have contact with their birth parents?"... I think they couldn't totally understand the situation... but I think people don't always realize that that's how adoption works. That you are a looked after child and then placed for adoption... and you are</i></p>
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	<p>looked at Sarah and said "Well who are YOU then?"...and Sarah said "I'm also his mum"...and we said our son hadn't been home very long so we wanted to keep them together ...and she said...in front of Courtney... she was 5 at the time...turned to her and said "what is she? Is she fostered? Are they in care?"... she [Courtney] just looked horrified...and just looked at us and.... your instinct is that you want to protect the children...and you just say "no, she's my daughter. This is her brother and this is their other mum." But it had quite a profound effect, in that every time we go to the hospital she says "I'm not going to see that woman that wasn't nice to us again?"...she's 7</p>	<p>identifies her... and they were completely fine with that but then... dealing with the medical setting and constantly seeing a different GP or going to specialist appointments...it's a new person every time, they only have the [legal] name on the system, so she would hear that.'</p> <p>'It would be good to have that on the radar now that she's adopted and has same-sex parents...what might have helped is if perhaps the local authority could have that communication with Primary Care, but maybe it would have helped [initially when children are placed] and could help in the future... like when a child's notes came</p>	<p>understand because initially [at the first appointment] the adoption hadn't gone through but sometimes I just feel like that gets asked too often and I think Courtney is a really bright kid... you just see her ears pricking up a little bit at them asking, whether they have to ring a social worker.'</p> <p>'I think I've done the best I can [at parenting]... but it's not really pleasant...to go to those appointments... every time we go to the dentist I get told to limit her sweets as she has got tooth decay and small cavities...and you feel like you're getting judged every time'</p> <p>'So whether or not they understand adoption...</p>	<p>the adoptive parents but you don't have the Adoption Order [as there is a timeframe and a court process that has to be adhered to]... I think they [the healthcare professionals] were a bit more questioning then. And they [Courtney and Michael] were younger as well, so it felt a bit easier being questioned like that when they were younger, whereas now when they're so aware, I think it's harder.'</p> <p>'[the surgeon said] "I must have met you when she had her previous surgery." Harriet got annoyed and said, "We tell people this all the time and I don't know why it doesn't get passed on... she didn't have her previous surgeries in this hospital</p>
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	<p>now and still refers to the incident as “that horrible woman at the hospital” and doesn’t want to go.’</p> <p>‘That terminology used [by the doctor]....to describe her. “what is SHE? Is she a care kid?” Y’know she’s not an ‘it’, she’s a child and when you want to know that information there are other ways in which to ask it. And I think it was just ... you feel like this second class citizen because you didn’t give birth...some people think they have this automatic right to talk about you...in that manner...And talk to your children disrespectfully just because they’re children. Like they don’t matter. She had no idea whether she was</p>	<p>through...the notes came through but all the immunisations were missing.’</p>	<p>you get asked “has she been sexually abused?” whispered in front of her. I feel that there should be some sort of note so that they’re not [asking this in front of them]. [The notes should say] this is an adopted child. Anything that is medically relevant, should be held in there. I don’t know what those kind of notes look like...but they [the healthcare professionals] should not be asking that or playing catch up or trying to find out what’s going on with this child who’s going across the room hiding under things.’</p>	<p>and we weren’t there for them, because we have adopted her.” I think Harriet was probably more annoyed because this consultant had just been talking at me, but people often presume that we have been through the entire process with her and that we’ve had everything explained antenatally and that we’ve already been through the intensive care and everything with the previous surgeries, and we haven’t. I think that when that kept being said, it started to annoy us, when we were feeling tired and didn’t really feel very acknowledged of the journey we’d all been on. I think we always feel like we’re playing catch up and because she was older when she</p>
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	<p><i>adopted or not, we could have given birth! So [she] just talked about [us] like [we] are a piece of paper...like [we] are not here.'</i></p> <p><i>'I think it's still that vulnerability. He knows he's our son and we're going to be together forever...but I wonder if there's always that element of him wondering if something is going to change....that I don't know if he'll ever fully accept....there are still little things...he'll say 'oh I'm not going anywhere.'</i></p> <p><i>'If he does want to ask something that's sensitive in terms of birth history or medical history, he gets them busy playing with something or takes one of us aside and asks us.</i></p>			<p><i>came to us, it was hard to replicate that experience that people would obviously go through when they find out antenatally, when they have appointments where you are talking as adults where you can have a conversation without the children there. Whereas our first time we met with the [specialist] nurses, they [Courtney and Michael] were both there, very aware. We did feel like we were always trying to piece together the knowledge a bit more than I think we would have done if we had been where we started from pre-birth.'</i></p> <p><i>'People presume that we've been through the whole [medical] journey with Courtney...we're probably sometimes</i></p>
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	<i>He really considers their feelings.'</i>			<i>treated the same when we shouldn't be and there's not actually been the acknowledgment of that, and then sometimes we have been treated differently. For a while, when we had outpatients appointments, we would often be asked to see different members of staff again... or we would ask to have a bit more time with the consultant again. So I think when we've really asked, they have acknowledged that there's a difference there, in a positive way and given us a bit more support to understand more about her condition.'</i>
Intersectional identity of lesbian parented adoptive families accessing healthcare	<i>'Is that even a relevant question to ask [why were they adopted?]. Is her birth history relevant at all when she is</i>	<i>'I said "look I'm not taking her to the doctor again because they have a habit of sectioning black</i>	<i>'We have been treated differently as a family. Whether that's because we're two women or because our children</i>	<i>'We always hear the terms 'real mum', 'birth mum', 'biological mum', 'Who is mum?' But the one woman in the Walk-</i>

	<p>7...and has come with a chest infection...or has an injury? It has stayed in our mind that this has happened and when we go to the hospital I automatically have a guard up, for example to see people that we don't know. She's got speciality teams that know her and we don't have to go through the rigmarole each time of...this is who we are...we adopted her..etc. But I still have my guard up when we have to see someone and we are going together knowing at some point it's going to come out. It's not a guard up because I'm ashamed of it, it's a guard because I want to protect the kids because I don't want them to turn around in a couple of years' time and go "why</p>	<p>people"... so [Harriet] took her...she got an inhaler straight away...'</p> <p>'I sometimes feel that people will talk to you [Harriet] more...I do think it's a colour thing. We mainly deal with White and Asian health care professionals and there's only one Black doctor that we've dealt with... and that's Dr xxxx who talks to all of us. White and Asian [health care professionals] will directly speak to [Harriet] more than they speak to me. I know it sounds really bad, but I'm used to it.'</p> <p>'She [healthcare professional] asked who was Mum, and we said both of us, and we said after that she's adopted, and that is something that we automatically</p>	<p>are adopted. It's sometimes hard to tell which one is which. Y'know when people refer to their 'real' parents rather than us.'</p> <p>'If they read our file and they are substantive doctors and not locums it helps. But we make the effort now if the children have got to go to the doctor's... we ask if Dr xxxx is in and I would go for that person even if it's the next day as they understand the adoption and being gay... I think potentially I would probably wait'</p>	<p>In Centre, she just said "well how can you both be mum?" ... and I said "because we are. She's adopted" and she said "so which one is the mum?" and I said "well neither of us are her biological mum." and we had to use those words because she couldn't get it.'</p> <p>'I think we've maybe been treated differently in the sense that sometimes people remember who we are, when I think maybe otherwise they wouldn't. You can tell they're thinking, "it's the lesbian couple who adopted".'</p> <p>'They do direct stuff to Sarah instead of me and if Courtney's sat on Sarah's knee when somebody walks in and I'm sat beside or I'm out</p>
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	<p>do we have to say that [that they are same-sex parents with adopted children] every time? Are we not a normal family?" Because we are a normal family. I guess for some people it's not...but then I've always maintained don't persecute my kids for something that you don't agree [being gay and adoption] with because it has nothing to do with them. The easier thing is to pretend that we did give birth to them...but if they're there...you don't want them to feel shame...that we're ashamed of the fact that they're adopted...because we're not, we're very proud of how we got our children. But...we want to protect them, but to protect them we have to lie. About where they</p>	<p>say anyway. It's just easier because it stops further questions...and because of the reactions that we had in the past. That's what happens isn't it, whatever you've experienced in the past you just prepare for it in the future. It's not that we mind saying it... it just stops the whole...who's mum?...then going through the whole conversation so we just say "we're both Mum, she's adopted" and then that's it.'</p> <p>'The difference was that there was just me so suddenly all the issues disappeared because he was my son and we went through his birth history as if it were my history. And you almost can ignore it [the fact he's adopted] because</p>		<p>getting a drink for us, then they'll assume that she's the mum. I think it has had an impact and I think there's other factors as well that have meant I have taken things on board more... because I was off on adoption leave first, I got to grips with the health stuff more quickly. But I think it probably has had an impact in that, in a health situation, they are not addressing us both equally... but I think in most situations where the heterosexual couple who are parents of the child with a similar condition to Courtney, the mum takes on a lot of the day-to-day stuff.'</p>
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	<p><i>have come from. I don't want them to learn that they have to lie about who they are and where they have come from. Because you shouldn't have to.'</i></p>	<p><i>it's not worth the hassle sometimes. You almost pretend...and you shouldn't have to pretend when they go..."giving birth...was it a normal delivery", "yes" because it's easier for him and it's easier for me and it's not going to affect the care that he's going to get. So if it's not going to affect it why do you need to know?! It's a self-preservation thing. All I want you to do is give my son some steroids for his croup so that I can go home with him and how he was born and where he was born doesn't actually matter.'</i></p>		
<p>Reflective imagery of lesbian parents and adoptive families</p>	<p><i>'They had a form at the hospital...where we just got put as adoptive parents, we don't get full status as parents...as if there's another parent somewhere hiding or</i></p>	<p><i>'McCain are doing good...and Vauxhall... but she was pregnant as she was taking her to the hospital so it was quite a positive one... we actually rewound it</i></p>	<p><i>'We had to register him [Michael] at reception [primary care setting] and it [the form] had the usual...mums name...dads name...the usual. So we crossed</i></p>	<p><i>'[when the form states] mother and father! We crossed it out and put parent and parent and we actually made a change to the form. I mean in that respect we</i></p>

	<p><i>there's another option. They've asked mums name and dad's name. We've said there isn't a dad and given both of our names so they've just put one mums name down and haven't bothered filling in the rest of it! Just literally left it empty coz [sic] that was too tricky.'</i></p>	<p><i>and said that it couldn't be right... but that was about giving birth... adoption no. I mean when you're in waiting rooms... and then there's a picture of a family, it's never two women or two men with a child, it's always a man and a woman.'</i></p> <p><i>'Specifically about adoption no, as in it doesn't say adoption...I have recently seen pictures of diverse families...that are portrayed as two women and children, two men and children and then mixed ethnicity and family diversity.'</i></p>	<p><i>out dad and just put mum.'</i></p>	<p><i>have crossed out father and put parents...and the way they do the form...a parent isn't an option on there... or to say is this child adopted and I think that should be on there.'</i></p> <p><i>'I don't think I've seen any anything... and I think I would notice. But, no I haven't seen anything that's LGBT purposefully inclusive... I find it pretty rare anywhere to see a lesbian couple with children depicted...and you do often see images that are one parent with a child or two parents of heterosexual families.'</i></p>
Professional expectations	<p><i>'[the surgeon] waited to do the surgery...until we were legally her parents because he wanted to give us that right to choose whether she had</i></p>	<p><i>'The health visitor came [to the house]...she didn't really understand adoption. She couldn't get that [adoption] into her head, I mean in the</i></p>	<p><i>'I don't expect them [health care professionals] to have a lot of adopted children [as their patients] but it should be something</i></p>	<p><i>'really important piece of the jigsaw'</i></p> <p><i>'in safe hands'</i></p>

<p><i>surgery or not. Rather than the social worker just signing a piece of paper and not really looking into whether it was good or bad...it [the consent form] was just a piece of paper to them. As a family we've been treated exactly the same as he treats everyone else and with consideration for the children and the terminology that he uses.'</i></p> <p><i>'He said "There's the two mums I've been looking for. Shall we walk and talk?"... and it was very normal and he's always been inclusive and great with the kids. I think he's helped restore their faith in healthcare.'</i></p> <p><i>'This person [healthcare professional] is in a</i></p>	<p><i>sense of terminology and I don't think it was the fact that it was two women, [it was] was adoption, because it was hard trying to get her to understand things like FAS [Foetal Alcohol Syndrome]. She didn't understand things like the fact that he [Michael] needed to have a blood test, because [of birth mother's history] he needed screening for hepatitis C or B...and I was pushing for an eye test and she said, "well I don't think that he needs one" but I said "well we've been told by a Paediatric Consultant that he needs an eye test"... and she couldn't understand that, and I was like "well do a bit of research"... I mean we were educating her more than anything else.'</i></p>	<p><i>where you as a person [who is] not in the medical professional shouldn't have to try to educate them about what they're supposed to be doing or there should be something where they should be able to easily access what they're supposed to do.'</i></p> <p><i>'One of the best relationships that we've had is with one of the female doctors at our local surgery. She's all about the child and so she puts us all together [in the consultation] and knows us quite well. She's really good and really respectful.'</i></p>	<p><i>'There was this anaesthetist who was lovely... I think that relationship was very important, and I think one of the things which had a massive impact on us trusting him was that he never asked [who was her Mum] and he obviously had read the notes or talked to somebody, or had just worked out the situation himself, acknowledging both of us all of the time and explained that when the surgeon came and we signed the consent that one of us could sign, or we could both sign. He explained stuff to us as if we were both parents, which it shouldn't really be a novelty, but it was.'</i></p>
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	<p>position of trust and we have to listen to them... our kids very much feel at home in the hospital setting for one reason or another....and I think it just questioned that safety in terms of these people are supposed to keep us safe...it was that vulnerability in Courtney and Michael in terms of "what are you gonna do as they've just said I'm a foster kid?" I think it's just, for her [doctor] I don't think it was a normal family structure and I think she didn't know how to deal with it. She was just so abrupt and lacked compassion and was so uncaring....whatever her feelings...it didn't come across that she was in a caring profession and there to make things ok for the children... with them having additional</p>			
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	<p><i>health needs we need to be aware that they're not fearful of professionals. It's [the hospital] going to be a part of their life so we make it a fun place to go and it's safe to be and everyone is there that's going to look after you...and she was the complete opposite of what they have come to believe is a safe place.'</i></p>			
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Appendix 4: Merged data analysis tool example

Data Analysis of X1

This data analysis provides the biographical information of the participant couple. Their story has then been broken down into the critical incident, like and other events as determined by Mertova and Webster (2007) critical event analysis. Following this, the coloured text highlights which section of the Clandinin and Connelly² (1990) tool the findings relate to.

Colours highlighting Broadening, Burrowing and Restorying depict each area of the Clandinin and Connelly² (1990) tool. The headings of critical, like and other events are in relation to Mertova and Webster¹ (2007) critical incident analysis tool

Clandinin and Connelly (1990) **Broadening**, **Burrowing** and **Restorying** (thematic analysis for composite character) and Mertova and Webster (2007) critical event analysis.

Biographical information: 37 female. 35 female. Same-sex marriage. White British. Health Professionals. 2 adopted children (non-biological). Male 7 years. Female 3 years. Both children have health needs and have accessed primary, secondary and tertiary care.

Critical Incident:

Son **attended ED** with **both parents and sister**. Parents were challenged as to who was the mother. Doctor assumed child was a looked after child. **Doctor 40's white Caucasian**.

he just looked horrified. kind of panicked what do we do? Your instinct is that you want to probably kill them but you can't. had quite a profound effect on him in that every time we go to the hospital or if we go to the doctors he says 'I'm not going to see that woman again. I'm not going to see that woman that wasn't nice to us?'...and he's 7 now and he still refers to the incident as 'that horrible woman at the hospital' and he doesn't want to go and see her again. Vulnerability. that this person is in a position of trust and that we have to listen to them....and y'know I think there is that vulnerability because we're not in a familiar environment. Hospitals are safe points are we're both nurses. I think it just questioned that safety y'know in terms of these people are supposed to keep us safe...it was that vulnerability in him in terms of 'what are you gonna do? – how are you going to protect me? – testing the role of a parent. Proving parental worth. Vulnerability. Coming out. Family constellation – what is a family?

Doctor – mother unsure if doctor didn't think it was a normal family structure. **What is a family?** Was it due to adopted children or gay parents? Uncompassionate. Uncaring. Unnurturing. Professional standards – GMC.

Mother felt devastated as 'let him down' because he'd heard. Terminology of HE, care kid, foster carers. He's a child, not a material possession. Tact and sensitivity. I was angry and she'd disrespected my wife. Overriding need to protect. Took a deep breath and gave benefit of the doubt. Professionalism. Use of language/terminology.

Have to pretend for the kids that it doesn't matter. Brush it off. Left a scar on our thoughts. Protection. Vulnerability of lesbian parents/parents in healthcare.

Like event:

Son attended specialist clinic with both parents and sister. Consultant (Asian female) stated that adoptive parents needed to ring his 'real mum' as she 'had a right' to know the diagnosis. I remember sat there thinking no she lost that right the minute she laid a finger on him.

Coming out. Use of language/terminology. Protection.

Other event:

Son attended ED with one parent and no intrusive questions asked. Self preservation – giving birth history – shut off to the past and deliver it as own. Issues disappear if only one parent goes. Hiding from the truth – protection of child.

Surgeon waited for adoption order to be granted so that adoptive parents could consent rather than social services. The fact that he waited to do the surgery on her until we were legally her parents um because he wanted to give us that right to choose whether she had that surgery or not. Rather than the social worker just signing a piece of paper and not really looking into whether it was good or bad...it was just a piece of paper to them Empowerment and autonomy.

Appropriate terminology to determine biological link of children and acknowledgment of 2 mums in a family by surgeon (40's ?white caucasian) As a family we've just been treated exactly the same as he treats everyone else and with such consideration for the children and the terminology that he uses. And if he does want to ask something that's sensitive in terms of birth history or medical history, he gets them busy playing with something or takes one of us aside and asks us. He really considers their feelings. . I think he's helped restore their faith in healthcare. Yeah, I think he has.

Medical paperwork states Mother and Father (have to cross out Father – take it in turns). Also detailed as adoptive parents – not entitled to full status as parents Modern family. as if there's another parent somewhere hiding or there's another option. Um..other ones were they've asked mums name and dads name. We've said there isn't a dad and given both of our names so they've just put one mums name down and haven't bothered filling in the rest of it! Just literally left it empty coz that was too tricky!! Education into parental responsibility and family constellations.

Meet new healthcare professionals: I still have my guard up when we have to see someone and we are going together knowing at some point it's going to come out. And it's not a guard up because I'm ashamed of it, it's a guard because I want to protect the kids because I don't want them to turn around in a couple of years time and go 'why do we have to say that everytime? Are we not a normal family?' Because right now we are a normal family...and it is...we are a normal family ...the easier thing is to pretend that we did give birth to them...but if they're there you're kind of...you don't want them to feel shame...that we're ashamed of the fact that they're adopted...because we're not, we're very proud of how we got our children. But almost we want to protect them, but to protect them we have to lie. About where they have come from. I also don't want them to learn that...that they have to lie about who they are and where they have come from. And it's not ok, because you shouldn't have to. Protection. Coming out.

Positive imagery within any healthcare settings about lesbian adoptive families. specifically about adoption no, as in it doesn't say adoption...families though...I have recently seen pictures of diverse families... portrayed as 2 women and children, 2 men and children and then your mixed ethnicity and family diversity. One was in a school. And the other one... I think it was the GP surgery, 2, that's it. [Education and awareness of family diversity](#)

Treated differently by various HCP: I think I've seen clear difference in dynamics when it's just been me going with one or both of the children as opposed to when we've both gone and it's a different environment but as a family we're spoken to completely differently. Um so in that respect I think that it's because we are 2 women that we get treated differently . I've noticed something with regards to different cultures and how we are perceived. [Cultural awareness and country of origin legislation on adoption and same-sex marriage.](#)

Initial Restorying Themes:

[Attitudes and Managing healthcare experiences](#)

[Terminology and bureaucratic transformation](#)

[Acknowledgment of sexual orientation](#)

[Protection of child](#)

[Professional standards](#)

[Vulnerability](#)

[Family](#)

Appendix 5: Pilot study publication (prior to print)

Disenfranchisement in British healthcare: being a lesbian non-biological mother.

Aim:

This paper explores the story of three non-biological lesbian mothers and their experience of accessing healthcare for their children. The commonalities and features that exist within the stories are forwarded as causation of the disenfranchisement non-biological mothers' experience.

Introduction

Previous research has shown that Lesbian Gay Bisexual Transgender (LGBT) parents may be reluctant to access healthcare for their children for fear of discrimination and acceptance (Chapman et al, 2012a. Shields et al, 2012). Chapman et al (2012a) discussed that the main concerns for the parents included health professionals attitudes whereby one parent was ignored or excluded from their child's care and also the necessity of the parents to 'come out' repeatedly due to their family constellation. The self-narratives in this paper are from a wider study that has raised emergent themes around being a non-biological mother and the rhetoric and language of discrimination encountered within British healthcare.

Background

The demography of a family has changed significantly in recent history as it is now more common for parents to be lesbian, gay, bisexual or transgender due to an increase in social acceptance and the dissolution of legal barriers with regards to parental responsibility (Ahmann, 1999. Shields et al, 2012. Mellish et al, 2013. Golombok et al, 2014). Within the United Kingdom (UK) a change in the law due to the passing of the Adoption of Children Act (2002) has allowed children to be adopted by same-sex couples since 2005. As a result of this change in British law, current viewpoints surrounding the health and wellbeing of children have widened due to the acknowledgment of alterations within family dynamics (Bramlett et al, 2007). It should be recognised that prior to the passing of the Adoption of Children Act (2002) LGBT

people were able to be and recognised as parents under British law, but they had most commonly become parents as a result of a previous heterosexual union, artificial insemination or surrogacy (Rose, 1994. Ahmann, 1999. Burkholder and Burbank, 2012. Golombok et al, 2014).

The change in British law has led to controversial views regarding same-sex parenthood (Mellish et al, 2013; Golombok et al, 2014) which when voiced in a healthcare setting could have an effect on the emotional health and wellbeing of children and their parents. In 2018, 1 in 8 of all adoptions within England were of children placed with same-sex couples (Department for Education, 2018).

There is a challenge inherent in healthcare practice that services and care must be reflective of the demographical population being served; service provision should be delivered inclusively (Shields et al, 2012a). Therefore, healthcare professionals should practice inclusivity particularly in terms of appropriate, inclusive terminology that is sensitive to the family makeup, and mindful that the rhetoric and language used for lesbian mothers will be heard and understood by the children attending with them.

Notwithstanding policy and government recommendations (Stonewall, 2008. Equality Act, 2010) homophobia remains present in many UK institutions, including the National Health Service (NHS) with patients and their families reporting inappropriate comments about sexual orientation (Bethel, 2009). Prejudicial attitudes and heteronormative terminology and rhetoric are aligned to non-biological lesbian mothers feeling disenfranchised due to not 'fitting the boxes' of heteronormative healthcare (Hayman et al, 2013).

There is an increasing number of children with LGBT parents within the UK (Hill, 2012. BAAF, 2014. Golombok, 2014) due to legal changes explored above, however, there are no real statistics available regarding the number of LGBT headed families (Hill, 2012); thus the urgency of addressing heteronormative assumptions by healthcare professionals is based on literature documenting subjective parental experience. That

said, the Equality Act (2010) demands that healthcare practice be conducted in accordance with inclusivity and non-judgemental terminology and rhetoric regardless of the family unit makeup, particularly in front of the children who can become distressed at the perception that their 'normal' is being defined as different.

There is a plethora of research available which details the experiences of LGBT people in the healthcare arena (Allen et al, 1998. Perlesz and McNair, 2004. Sharek et al, 2015), however there is a distinct lack of research concerning LGBT parents' experiences of accessing healthcare services for their children (Perrin and Kulkin, 1996. McNair et al, 2008. Mikhailovich et al, 2001, Chapman et al, 2012a. Shields et al, 2012). It is unknown as to why there is such a paucity of research for this community however suggested reasons are a reluctance to disclose sexual orientation (Neville and Henrickson, 2009) due to previous negative experiences within healthcare as a result of discrimination (Perrin and Kulkin, 1996. Perrin et al, 2004. Dibley, 2009. Edwards and Van Roekel, 2009) and discomfort in a heterosexist healthcare environment (Chapman et al, 2012a. Chapman et al, 2012b. Shields et al, 2012). However, due to an increase in LGBT parents, the reluctance to acknowledge their sexual orientation could cause some confusion to their children with regards to their family dynamic and therefore their identity when they are accessing healthcare services (Perrin and Kulkin, 1996. Shields, 2012).

This study therefore, sought to ascertain the experience of non-biological lesbian mothers accessing healthcare for their children and the rhetoric and language they faced. The assumption of heteronormativity of family constellation, led directly to disenfranchisement of these mothers within the United Kingdom healthcare system.

Method

A narrative inquiry design was adopted and was part of a wider study. Narrative inquiry allows the researcher and the participant, through storytelling, the chance to interact and thus become aware of incidences and values that matter to the individual

(Montello, 2014). This then allows contextualisation in relation to the social, political and cultural environment. A COREQ checklist was applied.

Participants and setting

The authors were the participants in the study and they self-define as being lesbian and are both non-biological mothers. A non-biological mother is one who has not conceived her child through surrogacy or IVF and therefore, shares no DNA with the child. This relationship can be through adoption or through a same sex relationship where the mother did not carry the child but her partner did.

Two interviews were conducted with 3 informants, which included 3 non-biological mothers (2 of whom were a married couple with adopted children and 1 non-biological mother due to In Vitro Fertilisation (IVF) with her partner) aged 36-45 years from two families. Their children ranged in age from 3 years – 11 years. All the informants were educated to Master's degree level and were registered health care professionals and working full time at the time of the interviews. Two informants were born in the United Kingdom and one was born in the Netherlands. All of the informants are British citizens.

Data collection

The strategy to recruiting participants for the pilot study was purposive sampling (Polit and Beck, 2004). The first researcher made contact with a colleague to ascertain if she would be interested in contributing. Therefore as a result of the interview, and the autobiographical nature, both became part of the research team. Both parties then decided the times for the interviews which were conducted via Skype in the privacy of their own homes. Two interviews were conducted with the first being to establish consent and the aims of the study and the second interview utilising a discussion surrounding critical incidents that had occurred when accessing healthcare for their children. During the initial interview demographic data was obtained which included

age, sex, gender, educational level, country of birth, ethnicity and the number of children that they were parents for.

Analysis

The data was analysed using a mixture of three frameworks; Webster and Mertova (2007) critical event analysis, Labov (1972) thematic organisation and Clandinin and Connelly (2000) thematic analysis. These methods were all utilised as no one set framework allowed the data to be analysed in its entirety and without meaning being lost. The audio files were transcribed and the transcripts were read several times to gain a sense of the entire content. The primary researcher transcribed and undertook the initial data analysis, following this met with her research colleague who was also a participant to discuss the interview content. The content was then coded using Clandinin and Connelly (2000) broadening, burrowing and restorying which allowed themes to be developed. The analysis was discussed, reviewed and revised throughout the analysis stage and finally four themes were identified.

Ethical considerations

Ethical approval was obtained from the University of Wolverhampton prior to recruitment.

Findings

The findings showed that the lesbian non-biological mothers had mixed experiences with regards to professionals' attitudes when navigating healthcare. The data analysis revealed positive and negative experiences and four themes emerged. The themes were: attitudes and managing healthcare experiences, acknowledgment of sexual orientation, professional standards and family constellation.

Each of the themes will be considered separately. These will be initially defined through exemplary quotations, prior to a fuller discussion aligned to the aims of the study.

Attitudes and managing healthcare experiences

The parents described difficulties in managing healthcare interactions and the attitudes of some staff members. Whilst some experiences were inclusive, the vast majority left the parent feeling insignificant, marginalised and somehow less of a mother.

I think it was just ... you feel like this second class citizen because you didn't give birth...some people think they have this automatic right to talk about you...in that negative manner...

and I've been visiting them [the children in a hospital setting] almost constantly for 3 days before anybody said do you want to cuddle with skin to skin... and she [nurse] recognised me as their parent, at that point... and nobody else had up until that point, I was just basically... I felt like I was the milkman because I brought the milk... brought the milk and the clean clothing...

Acknowledgment of sexual orientation

The parents divulged the intricacies of attending healthcare settings with their children and the requirement to justify their relationship to one another.

I think that's it though, when the two of us go together ...I mean...it's a long time... since I had had to walk into a room and announce my sexuality.... But since we've had the children, we walk in together and people go...'and you are?' oh we're both mum, we're together and this is our son...

... but I think also it's also that assumption isn't it... where you have to justify who you are... you have to tell them [health professionals] how to refer to you and do they do that with straight couples or do they just assume that it's Mummy and Daddy...

Professional standards

Due to the researchers who participated as parents all being health care professionals, they felt that professional standards were not always adhered to which led them to

question the professionalism showcased during their interactions, and the inclusiveness of the National Health Service.

she [doctor] was just so abrupt and uncaring and just lack compassiony'know whatever her feelings... it didn't come across that she was in a caring profession and there to make things ok for the children...certainly not for our son.

I've been to so many patients in my career that you just accept what they tell you, from trans patients to gay families to everything and the NHS Constitution states that you should treat everyone... not the same, but equally. So yeah I didn't realise how much it upset me at the time and it has made me more angry, but now it almost aggrieves me, for in the NHS there are still people that can't see beyond the normal boundary if you know what I mean, or what they perceive as normal...

Family constellation

This theme showed that the respondents felt that healthcare professionals often struggled with the concept of a family constellation that verged 'away from the norm' as they were unsure of what terminology to use and what 'role' was held by each person in the family.

I think it's just y'know for her I don't think it was a normal family structure and I think she didn't know how to deal with it... whether that's the fact we've got two adopted children or because we're two women...or a combination of both of those.

If you are not the biological mum, to then somehow be marginalized or lessened by being told that you are not the parents and I mean, when they wrote sperm donor on [the medical notes] they also...they wrote I was the father and I mean how ridiculous was that

Discussion

Non-biological lesbian mothers have a complex path to navigate within British healthcare. The findings show that British healthcare on the whole subscribes to heterosexism (Chapman et al, 2012a. Chapman et al, 2012b. Shields et al, 2012) and whilst there were some positive interactions, there were also a significant number of challenging situations. The parents felt that healthcare professionals often had heteronormative views of family constellations and that they also did not always honour their professional codes of conduct as they had negative attitudes towards their parentage and sexuality. This led to the non-biological lesbian mothers feeling a sense of marginalisation which is mirrored in the findings of Hayman et al (2013). A lack of knowledge surrounding routes to parenthood led to some healthcare staff asking inappropriate questions, which created a protective response from the mothers who felt compelled to defend their role and identity. This is further endorsed by Bethel (2009) and Hayman et al (2013) who discuss terminology such as sister or friend being used and questioning over the whereabouts of the father and conception methods, all leading to a sense of alienation and disenfranchisement. This study did highlight that whilst some healthcare professionals did not acknowledge the non-biological mother during an interaction, the non-biological mothers themselves perceive themselves to be as much of a mother as their biological counterparts and they believed, therefore, that they should be regarded as such.

Healthcare professionals have a legal and ethical requirement through their professional standards (GMC, 2014. HCPC, 2014. NMC, 2015) to provide care which is aligned to the Equality Act (2010) in order to ensure that all families are treated with respect and dignity. This is echoed in the NHS values and the NHS Constitution (DoH, 2009) which states that the NHS aspires to the highest standards of professionalism and the patient will be central to the services provided. The non-biological mothers in this study stated that they felt they had been subjected to behaviour from healthcare professionals, who had acted unlawfully and contrary to their professional standards.

This showcases that whilst there has been positive change in recent years, there still remains a rhetoric of heteronormativity which needs to be challenged.

Strengths and Limitations

The participants were recruited via convenience sampling through a professional connection and formed part of a small study. A drawback of convenience sampling is that it provides a limited number of participants with varying routes to motherhood (Polit and Beck, 2012), however this will be overcome when the larger study is completed.

The strengths of the study lie in the participants understanding of both professional issues and the challenges presented to lesbians. The participants being healthcare professionals themselves, provides the assertions made in this study with credibility to challenge heteronormative assumptions which are still evident within healthcare due to their knowledge of the infrastructure and combined experience.

Conclusion

The findings highlight that lesbian non-biological mothers experienced positive and negative interactions with health care professionals. It should be realised that a potential reason for this could be a lack of training into challenges that lesbians face when accessing healthcare. Whilst there may be people who hold homophobic views, on the whole progression within the United Kingdom (Equality Act, 2010) has seen an increase in tolerance and acceptance. This study has allowed the examination of lesbian non-biological mothers' experiences of accessing healthcare and has shown gaps in the literature. It is clear that the participants felt disenfranchised due to their non-biological status, however if health care professionals were educated on lesbian issues and non-biological parenthood then they may be able to alter the rhetoric of heteronormativity and allow liberation for all parents. Further research is planned through the larger study which will help inform clinical practice with regards to this marginalised group of parents.

Relevance to clinical practice

This study shows where healthcare professionals could improve their awareness and language to make lesbian non-biological mothers feel empowered to be part of their child's healthcare journey. Healthcare professionals must improve their knowledge of lesbian and non-biological parentage challenges and contest heteronormative attitudes and terminology to ensure that parents feel welcome and included.

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Appendix 6: Checklist of inclusive advice for healthcare professionals caring for lesbian parented adoptive families

Inclusive advice for healthcare professionals caring for lesbian parented adoptive families*

There is a distinct difference in terms of legal responsibilities between being adopted and being in foster care. A child in foster care is cared for by foster carers on behalf of the Local Authority and the biological parents. The foster carer has no legal rights or responsibilities in respect of the child. Adoption is the legal process by which a child or a family group of children who cannot be brought up within their biological family become full, permanent and legal members of their new family, which continues throughout their lifetime (AdoptionUK, 2020; Adoption Focus, 2021). Adopted children and their families may have had to contend with challenges and microaggressions whilst on their journey to becoming a family and indeed once their journey to adoption has completed. Sensitivity is essential to stop distress to children. In order to adhere to professional standards and the Equality Act (2010), here is a list of considerations that you could integrate into practice on a daily basis to aid in sensitivity and inclusion¹¹.

Lesbian parent specific advice:

- Do ask what our relationship is. Do not assume we are sisters or friends.
- Do not ask who plays the part of 'mum' and 'dad'
- Ask what our relationship is to the children. Consider if it is imperative that you know who gave birth, or if it is your own curiosity – if it is the latter, then the question is not important. By doing this you are acknowledging with certainty our family dynamic.
- Do include both of us (if we are a couple) in the consultation.
- If you are unsure, just ask us. We would rather that you acknowledge where your uncertainty lies, instead of making assumptions.

Adoption specific considerations:

- Use the term biological or birth parent, rather than 'real' parent.
- Do not ask the reasons for the child being adopted unless it is likely to contain important health related information. If you have to ask, then please take us to one side (out of earshot of the children).
- Do be aware that adopted children have a 'hidden history'¹² and this may have an impact on us all.
- Do not ask if we have contact with the birth family unless it is important to the children's ongoing healthcare.
- Do acknowledge that the child is ours, they are not a case number. They are a human being with thoughts and feelings and we are proud to be their parent/s.
- Do learn about the adoption process in England and the legal status of adoption and how it differs from foster care so that you have an awareness of what we and our child have endured.

Finally, advocate for us with other professionals and parents so that we know that you support our family and challenge any oppression. This way we will gain trust in you and our children will feel accepted and included.

*The suggestions are not exhaustive and serve as a consideration of terminology that could be used.

¹¹ This inclusive advice sheet has been determined from the findings of research undertaken by Lucille Kelsall-Knight (2020). Thesis title: Different Constellation and Shining Stars: Lesbian parents experiences of accessing healthcare for their adopted children

¹² 'Hidden history' – the history of a child who is looked after by the local authority, in kinship care or adopted and due to their life experiences and movement between placements, elements of their life story are not fully known. This may be due to information transfer failure, death of family members or inability to verbalise the experiences by the child (Kelsall-Knight, 2020).

Appendix 7: Literature review publication (awaiting print)

The experiences of Lesbian, Gay, Bisexual, and Transgender (LGBT) Parents Accessing Health Care for Their Children: A Literature Review

Abstract

Very little research has explored the experiences and challenges faced by lesbian, gay, bisexual, and transgender (LGBT)-parented families in regards to accessing healthcare for their children. This review aimed to investigate and analyse the current literature surrounding the experience of LGBT parents accessing health care for their children. Ten studies that met the inclusion criteria were identified and these studies showed that whilst many LGBT parents experience positive healthcare consultations, some still encounter discrimination and assumed heterosexuality. Therefore there is a need for bureaucratic transformation and specific training for healthcare professionals regarding challenges faced by LGBT families. In addition further research is required to explore LGBT-parented families' experiences of accessing healthcare in the United Kingdom, as the literature review did not identify any British research.

KEYWORDS lesbian, gay, bisexual, transgender, parents, healthcare, experience

Background

The family demography has changed significantly in recent history as it is now more common for parents to be lesbian, gay, bisexual or transgender (LGBT) (Ahmann, 1999; Shields *et al.*, 2012; Mellish *et al.*, 2013; Golombok *et al.*, 2014). There is a plethora of research available which details the experiences of LGBT people in healthcare (Allen *et al.*, 1998; Perlesz and McNair, 2004; Sharek *et al.*, 2015), however there is a lack of research concerning LGBT parents' experiences of accessing healthcare services for their children (Perrin and Kulkin, 1996. McNair *et al.*, 2008; Mikhailovich *et al.*, 2001; Chapman *et al.*, 2012a; Shields *et al.*, 2012; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstron, Borneskog and Almqvist, 2019. Kerppola *et al.*, 2019; Goldberg *et al.*, 2019). It is unknown as to why there is a paucity of research, suggested reasons are a reluctance to disclose sexual orientation (Neville and Henrickson, 2009) due to previous discriminatory experiences within healthcare (Perrin *et al.*, 2004; Dibley, 2009; Edwards and Van Roekel, 2009) and discomfort in a heterosexist healthcare environment (Chapman *et al.*, 2012d; Shields *et al.*, 2012).

Literature Search process and outcomes

The aim of this literature review was to identify LGBT parents' experiences of accessing health services for their children.

Specific objectives;

- To identify the LGBT parents' experiences of accessing health services for their children.
- To examine the methodological quality of existing studies.
- To make recommendations for further research.

Key words

The definition of terms utilised for the literature search were parent, LGBT, experience, accessing/seeking healthcare and children (Table 1) were expanded to include synonyms (Crookes and Davies, 1998). Boolean operators, "and", "or", were employed in the search to aid in the combination of terms (Bernard, 2013).

Table 1: *Definition of terms used to inform the search*

Term	Definition	Synonyms
Parent	Applies to all biological parents, regardless of their marital status or any person who has parental responsibility for a child or young person (Education Act 1996)	Mother Father
LGBT	Acronym for <i>Lesbian, Gay, Bisexual and Transgender</i> . The "LGB" refers to sexual orientation and if a person identifies as Lesbian, Gay or Bisexual. Sexual orientation is defined as a long lasting display of emotional, romantic and/or sexual attractions of men to women or women to men (heterosexual), of women to women or men to men (homosexual – Gay/Lesbian), or by men or women to both sexes (bisexual). The "T" stands for transgender or gender non-conforming, and is an umbrella term for people whose gender identity does not conform to that associated with the biological sex which they were assigned at birth (American Psychological Association, 2016).	Homosexual Lesbian Gay Bisexual Transgender
Experience	An event or occurrence which leaves an impression on someone (Oxford English Dictionary, 2016)	
Accessing/Seeking healthcare	The terms " <i>accessing</i> ", " <i>seeking</i> " and " <i>healthcare</i> " are used by many of the research papers to identify people who seek services for their health and wellbeing	
Children	The term 'children' feature highly in local and national guidelines and a child is commonly understood to be a person under the age of sixteen years (DOH, 2004)	

Inclusion and exclusion criteria

The inclusion criteria is shown and detailed in Table 2.

Table 2: Inclusion criteria used in the critical literature search

Inclusion criteria	Rationale
Key words	Key words were a necessary addition to the inclusion criteria to ensure that literature captured within the search addressed the review topic.
Primary research	Primary research is the most trustworthy and robust evidence (Aveyard 2014) therefore it was necessary for primary research to be included as a key inclusion criterion.
Date of publication	This initially was 2005 onwards due to the implementation of the Adoption of Children Act (2002) in the United Kingdom which allowed LGBT people to adopt children, however this timeframe yielded little data. Therefore the date of publication was extended to 1995.
Research whereby the parent was LGBT	It was important to focus the review onto the specific population as it allowed for distinct results to be retrieved.
Research where healthcare services were accessed for the children	There is a great deal of research (Allen <i>et al.</i> , 1998; Perlesz and McNair, 2004; Sharek <i>et al.</i> , 2015) available concerning access of healthcare services by adults, however there is a paucity regarding the access of services for children.
Worldwide	Initially only literature published in the UK and Northern Ireland was included however it yielded no results, therefore the inclusion criteria was extended to worldwide.
Peer reviewed	Peer review ensures that research findings are credible as they have been evaluated by experts (Bernard, 2013).

The databases CINAHL, Medline, SocIndex and Nursing and Allied Health were employed for the search. Ethos (open access repository for the theses at the British Library) was searched for theses or dissertations, but this yielded no results.

The initial 'hits' of 172 were reduced in number to 19 for final consideration for inclusion in the review. The abstract and an overview of the main body of the study were examined to allow an awareness of the research methodology to be gained and to determine if inclusion criteria had been met (Crookes and Davies, 1998). Nine were rejected due to (n=1) being a literature review and (n=8) the research was not specifically related to the topic and/or did not meet the inclusion criteria.

Overview of studies that form the review

Ten studies were included in the review. A qualitative approach with semi-structured interviews was adopted by seven of the studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019; Kerppola, 2019). One study (Goldberg *et al.*, 2019), with a sole focus on adoptive parents, was a mixed methods study. Two studies (Perrin and Kulkin, 1996; Mikhailovich *et al.*, 2001) were quantitative in nature but they also had qualitative inclusion by the employment of open-ended questions. Researchers in general focused on positive and negative experiences of LGBT parents within healthcare services and their satisfaction of care and interaction. The LGBT population were represented, however there is only explicit inclusion of a bisexual participant in two studies. The family constellation was also varied with differing routes to parenthood represented. An overview of the studies is shown in Appendix One.

Countries of origin; Australia (n=4) Sweden (n=3) Finland (n=1) USA (n=2)

Quality Assessment

The Critical Appraisal Skills Programme tools were utilised to appraise the literature (CASP, 2013). The two quantitative studies (Perrin and Kulkin, 1996; Mikhailovich *et al.*, 2001) need to be considered with care as they had low response rates (8% and 23% respectively), which are consistent with blanket community mail-outs utilised in previous work within this area of study.

All of the studies used purposive sampling. Snowball sampling also occurred in four studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012; Kerppola *et al.*, 2019). Four studies featured lesbians only (McNair *et al.*, 2008; Rawsthorne, 2009; Malmquist and Zetterqvist Nelson, 2013; Appelgren-Engstrom, Borneskog and Almqvist, 2019) and McNair *et al.*, (2008), Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019) were the only studies to identify the ethnicity of the participants. Perrin and Kulkin (1996), McNair *et al.*, (2008), Andersen *et al.*, (2017), Appelgren-Engstrom, Borneskog and Almqvist (2019) and Goldberg *et al.*, (2019) reported on the social

demographics of their participants. In the study by McNair *et al.*, (2008) all the children were biologically related to one of their parents; conversely in the study by Golberg *et al.*, (2019) there was no biological relationship between any of the children and their adoptive parents (n=224).

The sample sizes of the reviewed studies range between 11 and 255 participants due to the inclusion of both quantitative and qualitative studies. The two quantitative studies (Perrin and Kulkin, 1996 and Mikhailovich *et al.*, 2001) utilised questionnaires. The mixed methods study (Goldberg *et al.*, 2019) used Generalised Estimation Equations (GEE) and an open ended question to explore the experiences that the (heterosexual, lesbian and gay) adoptive parents had with their children's paediatricians. Open-ended questionnaires were used in two of the studies (Perrin and Kulkin, 1996; Mikhailovich *et al.*, 2001). The semi-structured interviews in the remaining qualitative studies (McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012; Malmquist and Zetterqvist-Nelson, 2013; Andersen *et al.*, 2017; Appelgren-Engstrom, Borneskog and Almqvist, 2019) were all conducted face to face, except for Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019).

Synthesis of Research Findings

Following appraisal and analysis of the studies, the following themes were identified by fingertip searching and highlighting areas of topic commonality in the research papers:

- Attitudes and Managing healthcare experiences
- Acknowledgment of sexual orientation
- Bureaucratic transformation

Attitudes and Managing healthcare experiences

Assumptions of heterosexuality with heterosexist language used within the health consultations and also a failure to recognise the non-biological parent were challenges endured by the participants in all except for one (Goldberg *et al.*, 2019) of the studies. Perrin and Kulkin (1996) divulged that their participants felt that some healthcare providers lacked an acceptance and/or knowledge and understanding of same-sex parents and they frequently needed to remind the provider that *both* partners were the child's parents. This was also noted by Malmquist and Zetterqvist Nelson (2013), Andersen *et al.*, (2017) and Kerppola *et al.*, (2019). Perrin and Kulkin (1996) found some children had received inappropriate diagnoses based upon the assumptions by

practitioners about family dynamic. In the study by Chapman *et al.*, (2012a) participants reported that healthcare providers often had little awareness of how to engage and/or refer to the parents; however some found it easier to manage this type of indirect discrimination than others due to their own resilience having overcome previous life experiences. The lesbian and gay (LG) (n=78) participants in the study by Goldberg *et al.*, (2019) did not discuss any heterosexist behaviour exhibited by their paediatrician, but accounted for this due to the parents actively searching for an LGBT or LGBT ally paediatrician to provide medical support for their children. Very few respondents in all of the studies felt that they had experienced overt homophobia. However they did express that the discrimination that they had been subjected to, centred around being asked excessive and evasive questions, including participants in Rawsthorne's (2009) study being questioned about the child's family of origin and the current family dynamic. This is further endorsed by Malmquist and Zetterqvist Nelson (2013) and Appelgren Engstron, Borneskog and Almqvist (2019).

Acknowledgment of sexual orientation

How LGBT people manage their level of disclosure or 'outing' will vary for each individual parent and is often shaped by their previous life experiences (Chapman *et al.*, 2012a). In Perrin and Kulkin's (1996) study, 77% of parents stated that their child's paediatrician knew if they were lesbian or gay. Overall the study found that parents who did not disclose their sexual orientation had a strong belief that if they did, their children would be viewed differently and their care compromised (Perrin and Kulkin, 1996). This concern is also supported by Mikhailovich *et al.*, (2001). However, many respondents (n=92) felt that their family constellation had many strengths and that paediatricians should be aware that the role of the family is similar to that of a nuclear family whereby there is a mother and father. The emergence of recognition of family constellation (Malmquist and Zetterqvist Nelson, 2013) and same-sex parental roles mimicking that of a 'societal norm' of a nuclear family is also echoed in the work of Kerppola *et al.*, (2019) who determined that acknowledgement of sexual orientation by healthcare professionals and empowerment of parents to define themselves as LGBT+ aided in them being recognised as co-parents.

Mikhailovich *et al.*, (2001) reported on various factors aiding self-disclosure, these were believing that it was relevant to the care of the child and also a political statement and commitment to being 'out' as LGBT. Participants in the study found that honesty

enabled the partners to be intrinsic to the consultations and therefore reduced the stigma associated with LGBT relationships and parenting. This is further supported by McNair *et al.*, (2008), Rawsthorne (2009), Andersen *et al.*, (2017), Appelgren Engstron, Borneskog and Almqvist, 2019, Kerppola *et al.*, (2019) and Goldberg *et al.*, (2019) who ascertained that positive experiences were achieved in healthcare when parents were open about their relationship and their relationship to their children. McNair *et al.*, (2008) commented on non-disclosure of sexuality and therefore being 'silent' and intentionally excluding a parent, as an avoidance tactic so as to protect the child from realising societal discrimination, and 'proud' disclosure whereby a united front was portrayed therefore reducing the confusion of the healthcare provider with regards to family constellation. The participant's main priority was their child's comfort and therefore their decision whether or not to disclose their sexuality was guided by their personal views (McNair *et al.*, 2008).

Chapman *et al.*, discussed non-acceptance of the parent's relationship and one couple was told 'we don't cater for people like you, you're not a family' (2012a, p.1131). Kerppola *et al.*, (2019) also focused on parental relationship and empowerment. They highlighted the importance of being visible and recognised as both an LGBT person and a parent in the healthcare setting, although they did feel that the healthcare practice routines were planned for heterosexual parents.

Bureaucratic representation

Bureaucratic systems employed within healthcare are inflexible and outdated as they do not take into account correct recognition of gender and family make-up (McNair *et al.*, 2008; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Kerppola *et al.*, 2019). In the study by McNair *et al.*, many participants felt that navigating the bureaucracy of the healthcare system was a challenge due to the non-recognition of lesbian-parented families on documentation as there was not 'a box they fit into anywhere' (2008, p.97). This was illustrated further as LGBT parents lacked representation on data-collection forms (Malmquist and Zetterqvist Nelson, 2013) and confusion by the healthcare professional over whether the non-biological parent could consent to medical treatment (McNair *et al.*, 2008). Numerous participants (Mikhailovich *et al.*, 2001; McNair *et al.*, 2008; Chapman *et al.*, 2012a; Malmquist and Zetterqvist Nelson, 2013; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) cited their frustration that their family constellation was not recognised within bureaucracy and it

is widely admitted that the various health systems still use ‘mother’ and ‘father’ in their forms and make heterosexual assumptions. Male participants discussed how they took it in turns to cross out mother and put the other parent in (Chapman *et al.*, 2012a). Mikhailovich *et al.*, (2001), Chapman *et al.*, (2012a) and Kerppola *et al.*, (2019) highlighted that their participants felt that the language used in consultations should be more inclusive to LG parents and that medical documentation should not insinuate that the only legitimate family type is the nuclear family. Andersen *et al.*, (2017) and Appelgren-Engstron, Borneskog and Almqvist (2019) acknowledge that same-sex parents are marginalised within healthcare due to the heteronormative language utilised on the health care forms, although does provide comment that some parents found that their healthcare provider was respectful of them and used the correct vocabulary and did not assume heterosexuality.

Bureaucracy and public displays should be transformed to make healthcare more supportive and reflect family diversity (Perrin and Kulkin, 1996; Mikhailovich *et al.*, 2001; McNair *et al.*, 2008; Rawsthorne, 2009; Chapman *et al.*, 2012a; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) by using gender neutral terminology such as ‘parent’ or ‘partner’, avoidance of the assumption of heterosexuality and forms/posters should be inclusive of diversity.

Conclusion

The needs and challenges of LGBT families may be different to those of heterosexual families (Mellish *et al.*, 2013; Golombok *et al.*, 2014). The healthcare provider should be aware of the diversity of the population in which they practice and should deliver inclusive services (Shields *et al.*, 2012; Andersen *et al.*, 2017; Kerppola *et al.*, 2019) through the use of appropriate terminology and also offer sensitivity to their families as children will attend healthcare settings with their parent/s. The documentation utilised in the health settings must be fit for practice; it must serve the whole community, and make sure that no person is excluded or discriminated against (DoH, 2015).

The studies all found that disclosure of sexual orientation to healthcare professionals was overall beneficial, however it should be recognised that even though a healthcare professional must act in a non-judgmental manner (GMC, 2014; HCPC, 2014; NMC, 2015), if they have innate homophobic attitudes then the LGBT parent may not receive as positive a reaction to the disclosure. Perrin and Kulkin, 1996; Mikhailovich, 2001;

Rawsthorne, 2009; Goldberg *et al.*, 2019 suggest that a healthcare environment should be provided that empowers the LGBT parent to disclose their sexual orientation. However it could be argued that placing posters on the wall and offering leaflets to verify an LGBT ‘friendly’ environment are not effective by themselves, as a poster alone cannot alter personal attitudes. Therefore it is imperative to ensure that all staff have received appropriate training in LGBT issues and challenges faced in healthcare by LGBT people (Chapman *et al.*, 2012a; Shields *et al.*, 2012; Wells and Lang, 2016; Andersen *et al.*, 2017).

Due to there being a distinct lack of literature from the UK, it is recommended that LGBT parents’ experiences in accessing healthcare services for their children in the UK are ascertained.

Key Points

- Healthcare institutions and professionals have a duty to improve the health environment by implementing strategies such as inclusive environments and engagement of LGBT communities whilst improving education surrounding LGBT issues.
- There remains rhetoric of normative heterosexism within institutions and thus non-inclusive environments. This in itself could prove challenging for both LGBT parents and their children as they navigate their way through a system whilst feeling the need to define and normalise their family constellation and therefore justify their identity.

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Appendix 8: Example of reflection written for revalidation of registration with the Nursing and Midwifery Council and reflexive diary

REFLECTIVE ACCOUNTS FORM

You must use this form to record five written reflective accounts on your CPD and/or practice-related feedback and/or an event or experience in your practice and how this relates to the Code. Please fill in a page for each of your reflective accounts, making sure you do not include any information that might identify a specific patient, service user or colleague. Please refer to our guidance on preserving anonymity in Guidance sheet 1 in *How to revalidate with the NMC*.

Reflective account: Senior Lecturer in Children's Nursing

What was the nature of the CPD activity and/or practice-related feedback and/or event or experience in your practice?

I attended the RCN Looked After Children conference and gave a poster presentation on the pilot study for my doctoral research.

What did you learn from the CPD activity and/or feedback and/or event or experience in your practice?

I have learnt that as a person, nurse and researcher I have grown tremendously throughout my career and the doctoral journey. I have an extended knowledge of looked after children and their access to healthcare. I was really proud to be able to showcase my research to peers who were interested in it and who were also keen to alter their practice as a result of it.

How did you change or improve your practice as a result?

I am aware that I have a professional responsibility to ensure that healthcare settings are inclusive environments whereby people receive equal, non-discriminative access. I realise that my research is now moving into the public domain and I have to be able to defend what I have written to the general public. Whilst I am not especially maverick in

my career, I do have a deep sense of morality and desire to prove a point. I need to utilise this wisely to ensure that the profession of nursing continues to evolve.

How is this relevant to the Code?

Practise effectively

6.1 make sure that any information or advice given is evidence-based, including information relating to using any healthcare products or services, and

6.2 maintain the knowledge and skills you need for safe and effective practice.

7.1 use terms that people in your care, colleagues and the public can understand

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum, and

7.5 be able to communicate clearly and effectively in English.

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

Promote professionalism and trust

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses and midwives to aspire to

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit

vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care.

